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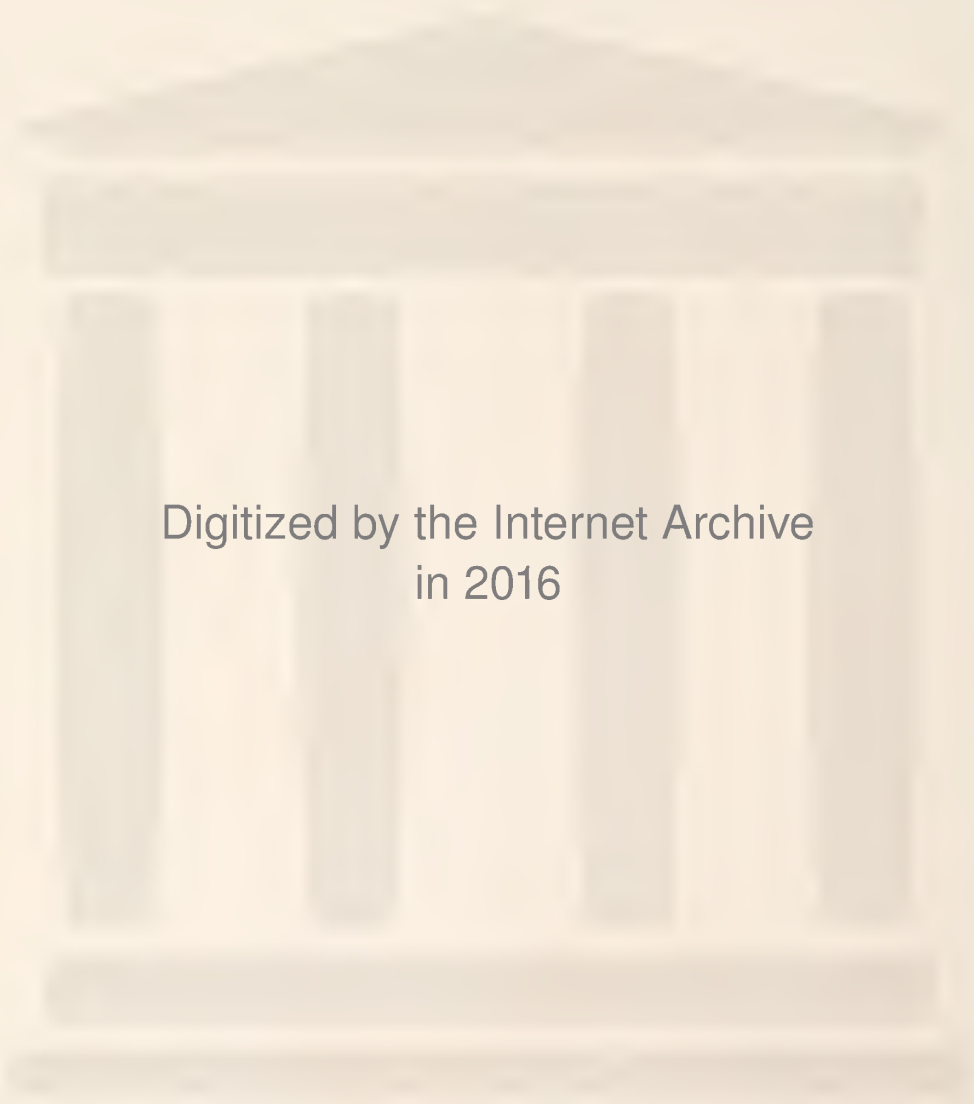
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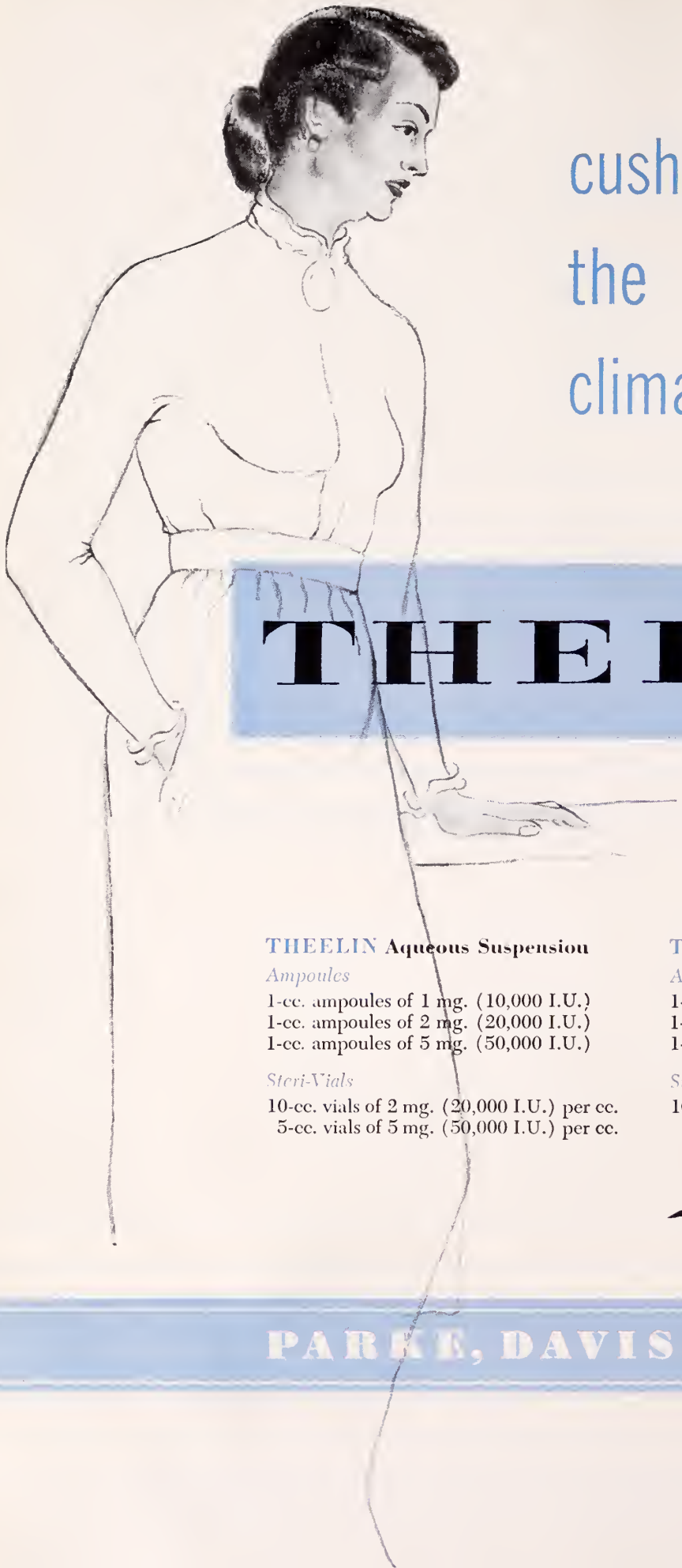

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1. Perloff, W. M.: Am. J. Obst. & Gynec. *58*:684, 1949.

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1. Moss, Henry N., and D'Alessandro, Domenic R.: The intensity and duration of the effect of Depo-Heparin on venous coagulation time in man. Am. Practitioner & Dig. of Treatment 2:309 (April) 1951

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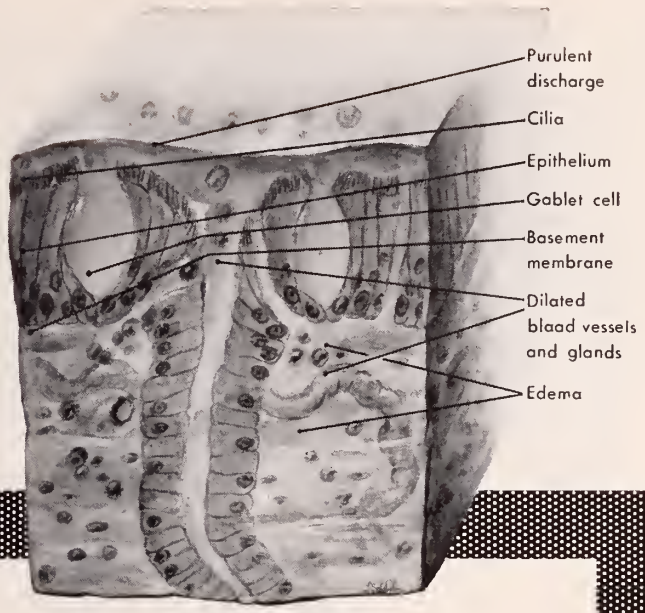

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1. Rehfuss, M. E., Albrecht, F. K., and Price, A. H.: A Course in Practical Therapeutics. Baltimore, Williams & Wilkins Co., 1948, p. 111.
2. Kelley, S. F.: In Cornell Conferences on Therapy. New York, Macmillan Co., 1947, Vol. 2, p. 156.
3. Gold, H.: In Cornell Conferences on Therapy. New York, Macmillan Co., 1947, Vol. 2, p. 151.

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1. Perloff, Wm. H. (1951), Treatment of the Menopause. II. American J. Obst. & Gynec., 61:670, March.

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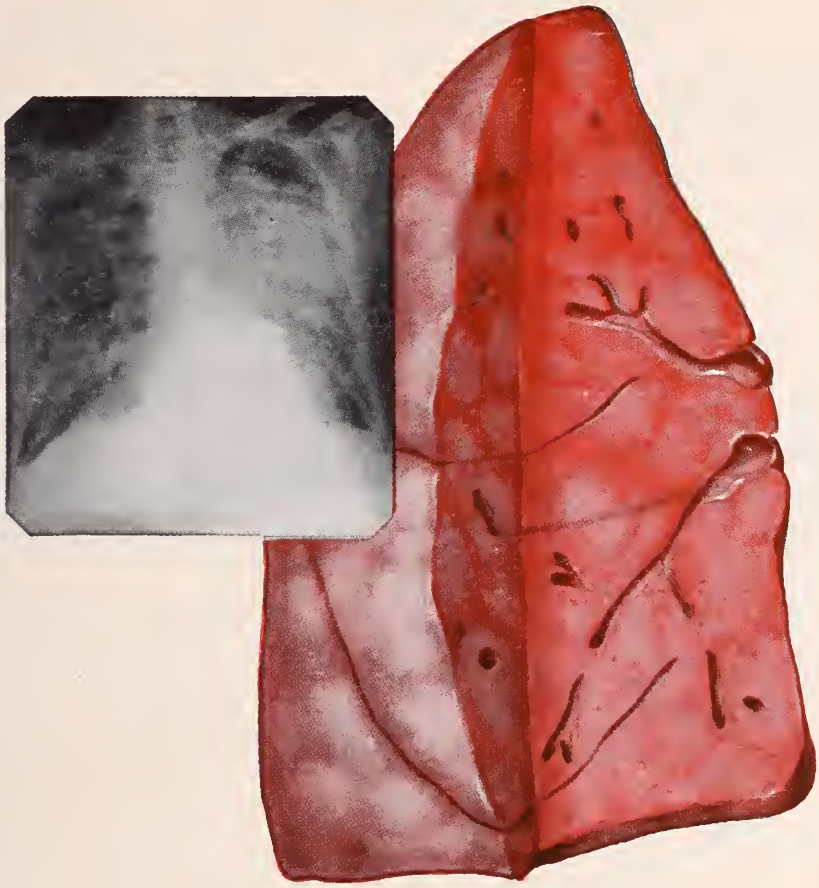

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Potterfield, T. G., and Starkweather, G. A.:
J. Philadelphia General Hosp. 2.6 (Jan.) 1951.

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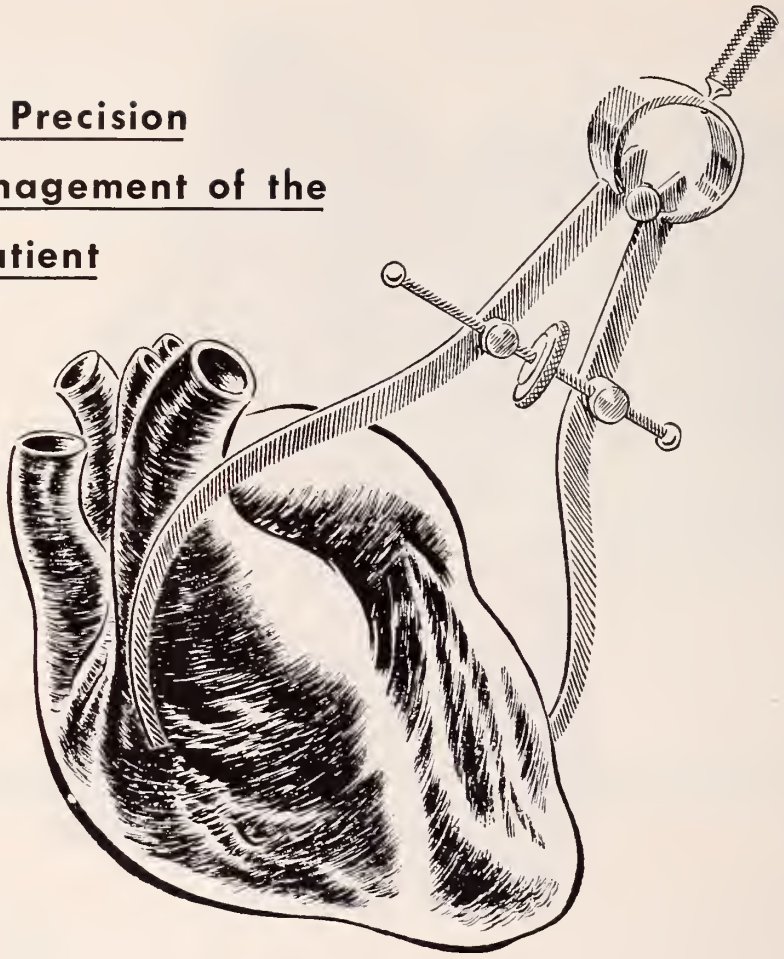

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The formerly held tenet that protein intake should be restricted for all patients with impaired renal function, in order to afford the kidney physiologic "rest," is no longer valid.[1] Except for infection and some neoplastic and traumatic disorders, the treatment of renal disease is nonspecific and essentially symptomatic. The clinical problem centers largely on diet regulation, in the hope of stimulating the kidneys to improve impaired function, without unduly risking harm.

Even in the presence of azotemia, a protein intake of 60 to 80 Gm. per day has not been found harmful to the renal patient. Low protein intake, on the other hand, together with urinary loss of protein may encourage the development of asthenia, anemia, hypoproteinemia, and edema.[2] Also pertinent to the dietary management in renal disease is the experimental finding that high protein diets in normal dogs promote higher urea clearance and greater renal blood flow than do low protein diets.[3,4]

Except in anuria, a protein intake adequate to maintain nitrogen balance has been suggested.[1] Although as little as 30 to 40 Gm. of protein per day may suffice for this purpose in the fever-free patient at bed rest, few occasions arise when 1 Gm. of protein per day per kilogram of body weight may not be given safely. In the presence of significant proteinuria, unless specifically contraindicated, the dietary protein may be increased beyond that amount in order to counterbalance the urinary protein loss.

Contrary to the still prevalent ancient belief among the laity, red meats are just as harmless to the renal patient as white meats; nor is there evidence that plant proteins are more beneficial in nephritis than animal proteins. As with the normal person, the dietary protein of the patient should be of high biologic value.

Meat, because of its high content of biologically complete protein, may contribute valuably to the protein needs of the nephritic patient. The nutritional importance of meat, however, is not limited to its contained protein. Meat also contributes highly significant amounts of iron and of the vitamin B complex, including niacin, pantothenic acid, pyridoxine, riboflavin, thiamine, and the newly discovered vitamin B_{12}. Other salient features of meat in the dietary of the patient are its high palatability, its stimulation of the digestive processes, its satiety value, and its easy and practically complete digestibility.

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1. Mann, G. V., and Stare, F. J.: Nutritional Needs in Illness and Disease, Handbook of Nutrition, American Medical Association, ed. 2, Philadelphia, The Blakiston Company, 1951, chap. 17, p. 351.
2. Weiss, S.: Diet and Bright's Disease, Connecticut M. J. 5:496, 1941.
3. Jolliffe, N., and Smith, H. W.: The Excretion of Urine in the Dog: II. The Urea and Creatinine Clearance on Cracker Meal Diet, Am. J. Physiol. 99:101, 1931.
4. Van Slyke, D. D.; Rhoads, C. P.; Hiller A., and Alving, A.: The Relationship of the Urea Clearance to the Renal Blood Flow, Am. J. Physiol. *110*:387, 1934.

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. . . . THE PRESIDENT'S PAGE . . . .

Listen to the Critics

IF WE are to win the fight to preserve private medical practice, we must satisfy the needs of the public. We must consider carefully every legitimate criticism and improve our methods of service whenever possible.

Three of the most common complaints concerning medical practice today are as follows: inability to get doctors to make house calls, long waiting periods in the doctor's office, and scarcity of physicians in small communities.

Each of these criticisms is being employed repeatedly in newspaper and magazine articles and in government propaganda to give the impression that there is a shortage of physicians and to create dissatisfaction with medical service. The fact that there is no real shortage of physicians in this country has been proved by many recent surveys.

The complaint about not being able to secure medical care in the home is a serious one, and apparently it is justified to a certain extent in some cities with 10,000 inhabitants or more. If doctors, including specialists, who find it necessary to limit themselves to office and hospital practice, will have a colleague or two whom they can confidently recommend for home calls, day or night, this problem will fade away.

The waiting period in the doctor's office is a difficult one to solve. The very nature of medical practice, with necessary and unpredictable interruptions due to telephone calls, obstetrical cases, accidents, and other emergencies, makes it almost impossible for any doctor to maintain a definite schedule. Courtesy and sympathetic understanding of the patient's side of the problem by the doctor's office assistants, with a full explanation of the cause of the delay, are probably the best methods of meeting this situation.

Many small communities which have lost their doctors by death or retirement are writing to the State Medical Society for replacements. The fact that they have not secured one is not because there are not enough doctors, but because their community is no longer considered a good place in which to practice.

Physicians can practice better medicine in groups and near a hospital with laboratory and x-ray facilities. Modern cars and roads which are kept open the year round have greatly increased the area in which a doctor can render efficient medical service to his patients, both in their homes and in his office. We must explain this to the public so that they will understand that the present system gives them better medical care than did the old plan with an isolated practitioner at every crossroad.

There is much to be learned from constructive criticism. By keeping an ear to the ground for legitimate gripes, the individual physician may act to prevent a minor public relations incident from becoming a major professional blunder.

Albin T. Heichmer M.D.

Civilian Medical Care For Army, Navy and Air Force Personnel and Their Dependents

THE rapid expansion of the Armed Forces has created a situation in which it is advisable for the civilian physician to understand the rules and regulations which govern the furnishing of medical care to service personnel and their dependents. The following article presents current regulations relating to the Army, Navy, and Air Force.

It is noteworthy that there is no provision in existing laws or regulations whereby dependents of military personnel in the Army, Navy, or Air Force may obtain civilian medical care at the expense of these branches of the service.

ARMY *

One of the most important and necessary services furnished the American soldier is adequate and timely medical care and treatment, including hospitalization. This service is provided for Army personnel in the United States generally by dispensaries, infirmaries, and hospitals located at the many Army installations throughout the country. There are many locations, however, where Army or other United States federal medical treatment facilities are not available when medical service is required by Army personnel. In cases of this nature, the services of civilian physicians, clinics, and hospitals are necessary. With the expansion of the Army and the deployment of Army personnel to practically all points in the United States either on a duty, travel, or leave status, the continued cooperation of civilian physicians and agencies is of utmost importance in providing adequate medical service to the U. S. soldier in time of need.

Certain criteria and procedures have been established in connection with the furnishing of medical service to Army personnel by civilians in accord with the current laws and regulations. These criteria define the conditions under which individuals of the Army may be authorized civilian medical care at the expense of the Army. These procedures include methods for reporting and receiving payment for treatment or hospitalization of Army personnel by civilian medical agencies.

Civilian medical care (other than elective) at the expense of the Army is authorized for commissioned officers, contract surgeons when employed by the Army on a full-time basis, warrant officers, enlisted personnel, cadets of the United States Military Academy, general prisoners and prisoners of war when these personnel are on a duty status or when they are absent from their place of duty, on leave or informal leave (pass) status. Applicants for enlistment in the Army and selectees also are authorized necessary civilian medical care at the expense of Army funds while they are being processed for enlistment or induction into the Army. Payment for civilian medical expenses incurred by Army personnel who are absent without leave is not authorized. Any obligations resulting from civilian medical care to Army personnel who are absent without leave are the responsibility of the Army individual concerned.

Normally, civilian medical care for Army personnel is authorized only when there are no other federal medical treatment facilities available. First aid or emergency treatment is authorized at any time, notwithstanding the proximity of Army or other federal medical treatment facilities. In this connection, emergency medical care may be defined as that required to save life, limb, or prevent great suffering. Surgical operations should not be performed without prior approval of military authorities, unless indicated as an emergency procedure. Elective medical treatment in civilian medical treatment facilities or by civilian physicians will not be authorized as Army funds cannot be used for payment of these services.

Due to limitation of funds available to the Army, medical care of dependents of military personnel from civilian sources, at Army expense, is *not* authorized. Dependents of military personnel may obtain available medical care at Department of Defense medical facilities only. Any obligations resulting from civilian medical care to dependents of military personnel are the responsibility of the dependents concerned or their sponsors.

As a general rule, local military commanders will furnish the civilian medical agency with prior written authority for ordinary medical care to Army personnel under his jurisdiction. In such cases, prior arrangements with the civilian medical agency will be made by the individual or by a proper military authority. For emergency cases treated without prior written authorization, the surgeon of the nearest military command should immediately be notified by the civilian medical agency, giving the individual's name, organization, nature of illness or injury and statement of the practicability of transfer of the patient to an Army or other governmental hospital. The civilian agency or physician then will be advised without delay by the appropriate military authorities as to procedures to be followed.

Bills for authorized medical care and treatment of Army personnel should be submitted to the commanding officer of the organization to which the patient belongs, or to the military authority who provided the authorization for the medical service. If the location of these individuals is not readily

* From Fact Sheet, Department of the Army, Office of the Surgeon General, Washington 25, D. C., 15 November 1951.

known, or if such military commanders authorizing treatment have moved to another station, the bill should be sent to the military authorities at the appropriate Army Area. For services rendered in Wisconsin, submit bills to The Surgeon, Fifth Army, 1660 East Hyde Park Boulevard, Chicago 15, Illinois.

The bill should show the full name, rank, and service number of the patient, place, and inclusive dates of treatment, diagnosis, and charges, all itemized separately. The duty status of the patient at the time of illness or injury also should be shown, such as duty, leave, or pass. Payment will be expedited if the following certificate is typed on the bill and signed:

"I certify that the above charges are correct and just; that payment therefor has not been received; that the services were necessary in the care and treatment of the person named above; that the services were rendered as stated; and that the charges do not exceed those customarily charged in this vicinity."

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(Signature of Payee) (Title or Capacity)

Answers to specific questions or further information concerning this matter may be requested of the military surgeon at the aforementioned address or from the Surgeon General, Department of the Army, Washington 25, D. C. Any difficulties that are experienced should be called to the attention of Army authorities in order that this program may function smoothly and render the American soldier the prompt and adequate care and treatment to which he is entitled.

NAVY *

The following regulations apply only to Navy or Marine Corps personnel. At this time there is no provision for the civilian care of dependents of such personnel at government expense.

20–1. General Summary

(1) Personnel on active duty in the Navy or Marine Corps are eligible for emergency or necessary medical or dental treatment at Government expense by any Federal activity, other than naval, having a medical service (Army, Public Health Service, and Veterans' Administration) under the following conditions:

(*a*) When on duty at a place where appropriate facilities or personnel of the Medical Department of the Navy are not available, upon the order of the commanding officer or senior officer present or, in the absence of a superior officer, upon their own application to the Federal activity concerned (art. 20–4).

(*b*) When on authorized liberty or leave in an emergency which does not permit return to the duty station or application to another naval activity having facilities for the necessary treatment.

(2) Personnel on active duty in the Navy or Marine Corps are eligible for emergency or necessary medical or dental treatment and hospitalization at Government expense in other than Federal hospitals under the following conditions:

(*a*) When on duty at a place where there is no Federal medical or dental facility, upon the order of the commanding officer or senior officer present or, in the absence of a superior officer, upon their own application to a civilian physician, dentist, or hospital (art. 20–4).

(*b*) When on authorized liberty or leave they become ill or are injured and the emergency does not permit application to a Federal medical or dental facility. Under such circumstances approval of their commanding officer should be obtained or, if this is impracticable, prompt report should be made to the commanding officer in order to permit investigation and suitable arrangements for transfer of the patient to a Federal institution or other appropriate action.

(3) The accounts of officer personnel receiving treatment in Federal hospitals other than Navy or in civilian hospitals at Navy Department expense will be checked for subsistence the same as when they are patients in naval hospitals (par. 5146.3, 1945 Manual).

20–2. Limitation on Emergency Dental Treatment

The expense of emergency dental treatment by other than a naval dental officer shall be allowed under the conditions specified in article 20–1 only to relieve pain or abort infection and upon the approval of a naval medical officer, if one is available. Emergency treatment shall not include the furnishing of prosthetic appliances including crowns or inlays, or the use of gold or other precious metals for fillings. (See arts. 20–14 and 20–15.)

20–3. Prompt Report Necessary in All Cases

Expenses incurred for medicine, medical or dental attendance, or hospitalization from sources other than the Navy may not be allowed in any case specified in article 20–1 unless the sickness or injury has been promptly reported to the Bureau by the medical, dental, or other responsible naval officer having cognizance of the case, or by the individual concerned when on detached duty or on authorized liberty or leave where a superior officer is not present. (Refer to arts. 20–7 and 20–8.)

20–4. Personnel in General

Personnel of the Navy and Marine Corps attached to and serving at a place where there are no Federal medical or dental facilities may be sent to other facilities upon the order of the commanding officer or the senior officer present. When on detached duty where a superior officer is not present, and naval medical or dental personnel or facilities are not available, the personnel should, if practicable, apply first to medical or dental facilities of other Federal departments or agencies. In the absence of Federal

* Excerpted from Manual of the Medical Department, U. S. Navy, Chapter 20; effective 13 August 1951.

facilities, they may apply to a civilian physician, dentist, or hospital for necessary emergency treatment.

20–5. Personnel on Liberty or Leave

(1) Personnel who require emergency medical or dental treatment while on authorized liberty or leave shall apply, if practicable, to the nearest naval activity in the vicinity; if emergency treatment is not available application should then be made to any other Federal agency having medical services. When Federal facilities are not available, the individual concerned or someone on his behalf should, if practicable, contact his commanding officer by telephone or telegraph reporting the emergency condition and requesting permission to obtain civilian medical or dental aid. Commanding officers may authorize such necessary emergency treatment as the circumstances seem to warrant, and should give appropriate instructions regarding submission of reports and bills and disposition of the patient upon completion of treatment (arts. 20–7 and 20–8).

(2) When the urgency of the situation does not permit obtaining treatment from Federal facilities or authority to obtain treatment from other sources, necessary emergency treatment may be obtained from civilian sources by or on behalf of the individual concerned, and reasonable expenses therefor may be allowed as a charge against the Navy; provided that, within a reasonable time, report is made to his commanding officer so as to permit investigation and suitable arrangements for transfer to a Federal institution or other appropriate action.

(3) Expenses for the employment of consultants or specialists shall not be allowed except when authorized in advance by the Bureau or, in extraordinary cases, when subsequently approved by the Bureau upon receipt of prompt report and satisfactory explanation as to the necessity and urgency of their employment.

(4) Civilian medical or dental treatment of personnel absent without leave is not authorized unless and until the individual comes under military or naval control.

(5) The expense of elective medical or dental treatment may be allowed under no circumstances. Civilian dental treatment, other than emergency measures to relieve pain or abort infection, is not authorized (arts. 20–2, 20–13, 20–14, and 20–15).

20–6. Retired Personnel

Retired inactive personnel and inactive members of the Fleet Naval Reserve and Fleet Marine Corps Reserve are not entitled to medical and hospital treatment at Federal expense in other than naval hospitals, except under provisions of paragraphs 16B2, 16B9, 16B34, and 16B35, 1945 Manual.

20–7. Reports Required in Cases of Emergency Medical or Dental Treatment or Hospitalization

(1) Report on NAVMED–U shall be promptly forwarded in duplicate to the Bureau in each case of any sickness or injury of personnel on active duty in the Navy or Marine Corps in which treatment is received from other than the medical or dental departments of the Navy. It is required in all cases in which medical, dental, or hospital treatment is furnished by civilian physicians or dentists, civil hospitals, or Government hospitals other than naval to Navy or Marine Corps personnel under circumstances that eventually may be used as the basis of a claim against the Navy Department. This report should be prepared by a naval medical or dental officer when practicable, and in the absence of such officers, by the senior officer present or by the individual concerned as soon as he is able.

(2) Commanding officers are responsible for bringing the foregoing to the attention of all personnel of the command who go on liberty or leave or who perform detached duty.

(3) When printed NAVMED–U Forms are not available, a typewritten report shall be made in duplicate giving the following information:

Name and rank or rating; date and place of birth; station to which attached; diagnosis; prognosis; status (leave, etc.). If on liberty or leave state exact period for which granted and the hours and dates of departure and return to station; circumstances; disposition; give dates on or between which services were rendered. By whom were the services rendered? When authority is given in writing a certified copy of same shall be attached. When authority is given verbally a certificate of the officer granting same shall be attached and shall show when and under what circumstances the services were authorized. Were the services of a naval medical or dental officer, or a naval hospital or dispensary available? In the case of an officer, the date of his orders and the name of the activity and disbursing officer carrying his accounts shall be stated, in order that his accounts may be checked by the Bureau in accordance with paragraph 5146.3, 1945 Manual.

(4) A supply of NAVMED–U's may be obtained from the nearest district publications and printing office.

20–8. Preparation of Claims

(1) All claims for expenses incurred for medicines, medical or dental attendance, or hospitalization not obtained from the Medical Department of the Navy shall be forwarded to the Bureau for adjudication. If approved by the Bureau, such claims will be forwarded to the Navy Regional Accounts Office, Washington 25, D. C. for payment. Payment of such claims may be made direct to the physician, dentist, or hospital, etc., rendering services or furnishing supplies, or reimbursement made to the individual receiving services or supplies if the cost thereof has been defrayed by him. (Refer to art. 20–8 (4).)

(2) Bills for treatment in Government hospitals other than Navy should be submitted to the Bureau for payment in accordance with existing regulations of the department or agency concerned.

(3) Unpaid bills for civilian medical or dental treatment or hospitalization of naval personnel should be forwarded to the Bureau for action. They should be prepared in duplicate, itemized to show the dates on or between which services were rendered or supplies furnished, and the nature of and charge for each item. The bills should be certified as "Correct and just; payment not received" with the autographic signature of the payee or, in the case of a company or firm, of a responsible official thereof, whose title or connection therewith should be indicated. Receipt of the services or supplies should be acknowledged on the face of the bill, or by separate certificate, by the person receiving treatment, or by an officer having cognizance of the case. The dates, charges, etc., should be carefully checked and verified when practicable. Separate certified bills should be submitted for services of special nurses, anesthetists, or other persons on a fee basis, unless the bill including such services is accompanied by receipts to show that the expenses have been defrayed by the physician, dentist or hospital submitting the bill, or by a statement to the effect that the individual is a full-time employee of the payee.

(4) In cases where the expenses have been defrayed and receipted bills are submitted, claim for reimbursement may be made by the person defraying the expenses by placing the certificate "Correct and just; payment not received" on the face of each receipted bill and signing same, or in cases of naval personnel, by completing and signing the certificate on the reverse of the NAVMED–U. In either of these cases the complete address to which the check is to be mailed should be indicated.

20–9. Services of Specialists

(1) When the services of a naval medical or dental officer are available and when, in his opinion, he is not sufficiently skilled to properly treat the condition, or lacks the proper equipment or facilities for the required treatment, the employment of a civilian physician, dentist, or other acceptable specialist, or procurement of special tests, examinations and hospitalization may be permitted upon prior authority of the Bureau after recommendation by the medical or dental officer in charge of the case. (Refer to arts. 20–5 (3) and 20–11 (2).)

(2) The provisions of article 20–9 (1) shall apply also to the employment of specialists or procurement of special services in connection with treatment of the personnel of other Government departments or agencies who are patients in naval hospitals, since the Comptroller General has ruled that the prior authority of the Bureau is required for these as well as for Navy patients (15 Comp. Gen. 874).

20–10. Procedure in Making Requests

Requests for the employment of a specialist or for services of a special nature may be made by letter or dispatch to the Bureau, according to the urgency of the case, stating the nature of the illness, the condition of the patient, and the necessity for the special treatment or services, together with an itemized estimate of the cost thereof.

20–11. Refraction of Eyes and Procurement of Eyeglasses

(1) Naval personnel who need new spectacles or replacement for damage or loss in line of duty and are unable to avail themselves of Navy or other Federal facilities should, if suitable prescription is not available in their record, request the Bureau's authority for eye refraction from civilian sources, via official channels, stating the need and estimated cost. If request for refraction is approved, the prescription from the refractionist with proper facial measurements and the Bureau's authorization should be sent to the nearest Navy optical dispensing unit within the continental United States or to the nearest Navy optical service unit outside the continental limits of the United States. The optical dispensing or service unit shall fabricate or cause to be fabricated the glasses as ordered by the refractionist and shall forward them for proper checking and fitting by the civilian physician or specialist concerned.

(2) Whenever practicable in the absence of Navy facilities, eye refraction should be obtained from facilities of the Army, Public Health Service or Veterans' Administration, with the above procedure being followed in filling the prescription. The prior authority of the Bureau is not required to obtain refraction in one of these Federal facilities; however, authorization should be issued therefor by the individual's commanding officer or the senior officer present.

(3) All naval personnel attached to Naval Shore Establishments and working in trades or areas determined to be eye-hazardous shall be furnished satisfactory eye protection. When corrective-protective glasses are required by these naval personnel, all such glasses shall be furnished by the Medical Department activity of the establishment as a proper charge to the appropriation "Medical Department, Navy." In some instances prescription for such glasses may be in the individual's record; otherwise necessary refraction should be obtained from naval sources, or, if impracticable, from other sources in accordance with instructions in the preceding articles (20–11 (1) and 20–11 (2)). The furnishing of protective goggles of various types with Plano heat-strengthened or hardened safety lenses to naval personnel, who do not require corrective lenses, is authorized as a charge to the appropriation, "Medical Department, Navy" only at activities under the management control of this Bureau. These protective goggles should be procured under authority of annual sundry purchase requisition.

(4) Bills, in duplicate, covering the cost of refraction shall be submitted in accordance with articles 20–8 (2) and 20–8 (3).

AIR FORCE*

The United States Air Force is responsible for the provision of medical and dental care to United States Air Force military personnel on active duty, and to their dependents in so far as facilities are available. Whenever it is feasible and practicable for Air Force personnel to receive medical care at Air Force medical installations they should do so. Conversely, Air Force medical installations provide medical and dental care to all Air Force personnel who may be assigned in the area, whether or not these personnel may be assigned to the particular Air Force Base.

Naturally it is not possible to have USAF medical installations readily accessible to our personnel in every geographical location. In those locations where we do not have such facilities, it is necessary to depend on other governmental or civilian agencies for these services. These agencies include medical and dental services of the Armed Forces (Army and Navy), and other federal agencies, such as the Veterans' Administration and the United States Public Health Service. When medical and dental services of government agencies are not available, care may be obtained from civilian sources at no expense to the individual, provided such care is a necessity and an emergency. Only active duty Air Force personnel on duty, leave or informal leave (pass status) or those people stationed where no other military or federal medical installation is available may utilize civilian medical care at Air Force expense. USAF military personnel absent without official leave (AWOL) are not authorized civilian medical care, but can receive treatment at any military installation. Dependents of active duty Air Force personnel are not authorized civilian medical care at Air Force expense.

All bills for services, including ambulance charges, rendered USAF military personnel by civilian physicians or medical facilities will include:

1. Full name, rank, service number and organization to which assigned for duty.
2. Duty status of patient, if known, i.e., duty, leave, or informal leave (pass).
3. Inclusive dates of treatment if hospitalized, otherwise, date and place of treatment.
4. Diagnosis.
5. Charges (itemized separately for services, drugs, x-rays, etc.).
6. A statement certifying that the bill is correct and just; that payment has not been received; that the services rendered and the medicine furnished were necessary; and that charges do not exceed those customary in the vicinity.

Payment for medical and dental service properly submitted from civilian sources to USAF military installations will be accomplished promptly after receipt of necessary authenticated vouchers. The civilian physician is advised to send the bill for services rendered directly to the Commanding Officer of the nearest Air Force Base.

* From Department of the Air Force, Washington 25, D. C., 12 July 1951.

A JOINT RESOLUTION

The following joint resolution, urging physicians and dentists to maintain records of services rendered to veterans of World War II, was passed at the 1943 session of the Wisconsin legislature.

"WHEREAS, It is essential to the recovery of federal war compensation by veterans of the present war that a given disability be shown to have resulted from and in connection with the military service of the claimant, and

"WHEREAS, It is also essential to proof of such service-connected disability that all treatment records kept by a physician or dentist of the claimant be available to military and federal authorities, and the absence of such a record may defeat the bona fide claim of a veteran; now, therefore, be it

"*Resolved by the assembly, the senate concurring*, That the state board of health, state board of medical examiners, the state board of dental examiners, and the several professional societies be requested forthwith to ask that all practicing physicians and dentists ascertain, so far as possible, whether patients are now or are on any subsequent date veterans of the present war, and that in the case of each such veteran his case history be preserved for at least 6 years after the date the last professional service is rendered by such physician or dentist. Be it further

"*Resolved*, That each of the above boards and professional societies be further requested to contact all of their respective licensees and members at least once a year for the balance of the war, and at least once each year for the first 6 years following the war, so as to remind all such persons of the importance to the war veterans of preserving such professional records."

Malpractice and the Physician*

By LOUIS J. REGAN, M. D., LL. B.

THE incidence of malpractice claims increased tenfold during the decade between 1930 and 1940. In some localities, malpractice claims have become so frequent that any patient with a less than perfect end result is a potential malpractice claimant. If this alarming situation were evidence that the medical profession was becoming increasingly inefficient, then the solution would of course be obvious. But the blunt truth is that the majority of all malpractice suits filed are without merit; more than half of them involve physicians who are above the median of their respective groups in skill, experience, and professional standing. The search for a solution to this problem demands an understanding of what actually constitutes malpractice, an analysis of the causes of malpractice claims, and a universal knowledge among physicians as to the positive steps which may be taken to decrease both the relatively few justified claims and the preponderantly greater number of unjustified claims.

Any Physician May Be Sued for Malpractice

The bringing of a malpractice action does not even suggest that the claim has merit; for any patient may bring such an action against any physician who has attended him professionally. Nevertheless, the practitioner who is the target of the accusation is damaged by the mere filing of the action. Accordingly, it is necessary that every physician understand what constitutes malpractice under the law.

What Constitutes Malpractice Under the Law?

The law requires that a physician who undertakes to diagnose or to treat a patient must possess the skill and exercise the care commonly possessed and exercised by other reputable physicians in the locality. If he holds himself out as a specialist, he must meet the standards of practice of the specialist in the designated field of practice. These legal interpretations of his duty are not changed if the professional services are rendered gratuitously. It follows, then, that no malpractice charge is justifiable unless the physician's service to the patient does not meet the requirements of good medical practice; unless in the diagnosis or treatment of his patient, the physician omits to do something he should do or does something he should not do in terms of accepted standards of practice. The standard of practice is always determined by what other reputable physicians in the community, or in similar communities, would or would not do in the care of similar cases.

This definition of standards needs further clarification; for medicine is not an exact science, and not all patients who are given medical treatment get well. Many are left with some disability or deformity. There are few conditions in which there is available a sole, specific, universally utilized remedy or procedure. There is frequently a great latitude for honest difference of opinion, and often the attending physician must exercise his best judgment in deciding which of the several methods to adopt. In certain circumstances, the physician's acts or omissions may be so unseemly and shocking as to be generally recognized as reprehensible and supportive of legal liability. On the other hand, complications or untoward and unexpected results are not uncommon, and the mere fact that a patient is not cured or does not progress favorably does not suggest culpable ignorance or negligence on the part of the medical attendant.

Under Law, What Skill and Care Has the Patient the Right to Expect?

In the absence of evidence to the contrary, the law presumes that a physician has exercised the ordinary skill and care required of him in treating his patient. He is justified if his conduct of the case would be approved by even a respectable minority of his confreres in the same locality. He may make a mistake in diagnosis or be guilty of an error of judgment; he may use medicines or methods of treatment different from those which some of his colleagues would have used; he may obtain a bad result instead of a satisfactory one; but no one of these things is sufficient to fasten upon him the charge of malpractice. Actionable malpractice consists in doing something that should not be done or in omitting to do something that should be done.

Malpractice Suits Lessen Public's Confidence in Medical Profession

It is of primary importance, of course, that every physician familiarize himself with his legal interpretation of what does and what does not constitute malpractice. But that is only the first part of the control of the malpractice contagion; for experience has taught us that the most meticulous attention to the dictates of good medical practice is not sufficient to ward off unjust claims and that no physician, regardless of his excellence, is immune. The misunderstanding, indeed the ill will, which has been engendered by the great number of unjust malpractice suits has tended to break down the public's confidence in the medical profession. This situation has important and far-reaching implications for both the public and the medical profession; for the public interest is adversely affected when the physician in

* Reprinted, with permission, from the Journal of the American Medical Association, September 2, 1951.

caring for his patient is forced to give thought, time, and energy to safeguarding himself against the possibility of an unjust malpractice claim. The public should be informed of the facts of this problem, for in the long run, it is the public—in the persons of individual patients—whose well being is being jeopardized. There is no relationship outside the family which is so personal and intimate as that of physician and patient, no relationship in which the character, integrity, and conscience of one party are so important to the well being of the other. The overwhelming majority of physicians faithfully and unselfishly meet the demands and obligations of their calling; and the majority of patients do not unjustly file malpractice suits. The acts of the ignorant, the greedy, the callous few—among either patients or physicians—must not be permitted to destroy the merited esteem in which the profession as a whole is held.

How Much Shall the Physician Tell His Patient?

As a basic step in improving the situation, the physician must realize that at all times he is obligated to act with the utmost good faith toward his patient. Thus, if he knows that he can not accomplish a cure or that the treatment adopted will probably be of no benefit, he is duty bound to advise his patient of these facts. It is extremely doubtful that a physician has a therapeutic privilege to withhold a specific diagnosis from a patient who is sick with serious or fatal illness. To the contrary, the confidential relationship requires in ordinary circumstances that the physician make a frank and full disclosure of all the pertinent facts to any adult and mentally competent patient. Such completely open handling of a case would do much to improve the physician-patient relationship and to remove the possibility of unjust malpractice actions. However, there are other unavoidable and even psychological factors in the practice of medicine which must also be considered carefully in this respect.

Factors That Promote Malpractice Suits

If physicians were always able to obtain perfect results there would be, of course, no malpractice actions. But deaths, untoward and unexpected results, continuing disabilities, and complications occur and will continue to occur. Whether or not the uncured patient brings an action is often determined by his feeling toward the physician. Patients who have a feeling of friendly trust for the physician and who believe that everything possible has been done for them are not so likely to sue for malpractice—even when bad results ensue. Malpractice suits more often arise if the patient is resentful of some fancied or actual affront, if he believes that he has not been sufficiently closely attended, or—above all—if some third person raises a doubt in his mind as to the propriety of the treatment. In regard to this last point, it would be sheer folly to assume that the "third person" is always—or even most often—a layman who is uninformed about the facts of the case. Regrettably, many of these people are physicians who are also uninformed about the details and facts but who precipitate unjustifiable suits by criticising directly or by implication the work of physicians who have cared for particular cases.

Another potential danger to the physician-patient relationship arises from the physician's lack of attention to certain elements of patient psychology as factors in malpractice causation. Although the patient is sick or injured when he comes to his physician, he nevertheless visualizes himself as he was prior to becoming sick—with his body structures intact. Thus, unless the physician understands this viewpoint and prepares the patient properly, the patient with a fracture, for example, is likely to compare the final result with the part prior to injury, not with the injured member as presented to the physician. As another example of patient psychology, the average patient is not disposed to understand an error in diagnosis or the failure to make an early diagnosis. Or again, the unwarned patient is not happy with the surface tissue changes which are some times associated with deep x-ray therapy.

An analysis of malpractice claims reveals the significant fact that they arise almost invariably out of the first course of treatment. In other words, it is rare indeed that an old patient instigates a suit against his physician. It is obvious, then, that from the very first contact—indeed, especially with the very first contact—the physician should do everything within his power to develop an honest, frank, and psychologically sound relationship with his patient.

How Physicians May Safeguard Themselves Against Malpractice Suits

The foregoing discussion has analyzed what malpractice is and what can be done in the physician's conduct to avoid real malpractice or to forestall the filing of an unjust claim. But it would be completely unrealistic to assume that any course of conduct on the part of the physician would prevent his being unjustly sued for malpractice. Good medical practice in itself is not enough; the physician must be able to defend his actions by proof of what he has done. He must not only know his legal duty to his patient, but he must fulfill it. He must know and take advantage of every measure to protect himself against the unjustified claim of malpractice. Under present circumstances, it is absolutely foolhardy for any physician to be ignorant of or careless of malpractice prophylaxis. He must take positive actions carefully based upon his legal responsibilities and liabilities.

To begin with, a physician is not legally obligated to undertake the care of any patient. But from the time he assumes the responsibility until he is discharged or withdraws from the case, he must give—or be sure that there is given—the care and treatment required by the condition of the patient. Before a physician may, without legal liability, with-

draw from a case he must give reasonable notice of his intention and allow the patient reasonable opportunity to fill his place.

By notice or special contract, the physician may limit the service he is to render. He may agree to treat the patient only at a certain place, or for a limited time, or for certain conditions. On the other hand, he may increase his obligation by expressly agreeing or warranting that he will effect a particular result; in this circumstance, he will be liable on his contract or warranty if he fails to fulfill the agreement. A physician is not an insurer of results unless he makes himself one by his special promise.

Many malpractice actions are brought as the result of some unwise statement made by the attending physician, or his partner, assistant, or office nurse, to the patient or to a friend of the patient. Care should be taken to avoid making any remark constituting an "admission" of fault, or one which may be construed as such. It is understandable that such remarks have been made under emotional stress or when exercising "hindsight" in the face of an unsatisfactory result even when good practice has been followed throughout. A single careless statement might create liability for damages where actually no liability exists. The effect of such a remark when reported to a jury is incalculable and almost impossible to counteract. Further, an admission on the part of the defendant may free the plaintiff from the necessity of offering medical expert testimony.

Expert Testimony and Res Ipsa Loquitur

Generally, the proof of a physician's negligence must be established by the testimony of medical expert witnesses. The application of the doctrine of *res ipsa loquitur*[1] in a case gives rise to an inference of negligence on the part of the defendant, and relieves the plaintiff of the necessity of proving the alleged malpractice by the testimony of experts. It places on the defendant the burden of making explanation, if he can, to offset the inference of negligence; and by the majority rule a question is created for the jury, regardless of any and all evidence presented by the defendant.

The doctrine of *res ipsa loquitur* has been held applicable in the field of malpractice chiefly in cases which involve (1) slipping instruments, (2) sponges left in the tissues, (3) burns from heating modalities, (4) roentgen radiation injuries, generally limited to cases wherein the roentgen ray is being used diagnostically, (5) infection through the use of an unsterilized needle or instrument, and (6) injury to a portion of an anesthetized patient's body outside the field of treatment or operation.

[1] *Res ipsa loquitur* (literally, the thing speaks for itself) is a doctrine of the general law of negligence. It is held applicable whenever one person is injured by an instrumentality entirely in the control of another person, the use of which does not ordinarily result in injury if the person in control exercises due care.

A Good Case Record is a Valuable Safeguard

The importance of good medical case records, as a factor in malpractice prophylaxis can not be overestimated. A good medical case record should contain a history[2] of the case and a physical examination of the patient, together with reports of all indicated laboratory studies. These data constitute the foundation of the medical record and will generally serve as the basis for at least a working diagnosis. If diagnosis is not possible, consultation is desirable. Consultation reports must be in writing. Thereafter, a good record will reflect (by means of progress notes) a sequential history of the case, its course, complications, and sequelae and, thus, the justification for further or changed investigation and treatment. Such a record will contain a statement of all treatment rendered in the case. Copies of special forms and of reports used or made in a particular case are also a part of a good record. It is desirable that an attending physician ask himself from time to time what he would wish to have in the record of the case under treatment in the event he should later be called upon to justify in court his conduct of the case. If a patient discontinues treatment before he should or fails to follow instructions, the record should show it. A good method is to file a carbon copy of the letter sent to the patient advising him against the unwise course.[3]

Unwarranted Professional Criticisms Promote Malpractice Suits

The precipitating cause of a majority of all malpractice actions is found in the unwise comments or criticism of physicians with regard to treatment given to patients by other physicians. Commonly it is criticism by a succeeding physician of the work of his predecessor. Various authorities have estimated that 50 to 80 per cent of all the suits for malpractice would be eliminated if such destructive criticism could be stopped. It is profitless to attempt to determine why physicians are so prone to criticise destructively and unethically, but the results of it are deplorable. Legitimate criticism rests only on full knowledge of the facts as gathered from all parties; from the physician who treated the patient, as well as from the patient.

Other Preventive Precautions

The importance of tact can hardly be overemphasized. It should be manifest especially in the handling of the patient and the patient's family; in the avoidance of fee disputes and unwise efforts and methods in the collection of fees (considering the provisions of the statute of limitations); in the avoidance of overoptimistic prognoses and especially of any promise constituting a guarantee of a par-

[2] It is important to indicate the source of the medical history (from the patient, member of family, etc.).

[3] There is a legal presumption that a letter mailed has been received by the addressee; but there is no presumption that a letter has been mailed.

ticular result; in the avoidance of betrayal of privileged communications; in the avoidance of making any statement constituting (or which might be construed as) an "admission" of fault or negligence; in the avoidance of any reference to malpractice insurance protection; and in the securing of legal advice before making any statement in regard to a malpractice claim or suit.

Liability for Acts of Others

In addition to being responsible for his own acts and omissions, a physician encounters, in his everyday practice, instances in which he may also be responsible for the negligent acts and omissions of others. Thus, he is responsible for the acts of his assistants and employees, for their negligence occurring during the course of their employment. Where doctors practice as partners, each partner is liable not only for his own acts and those of his partner, but for the negligent acts of any agent or employee of the partnership.

When two independent practitioners are caring for a patient, each is liable not only for his own acts but for doing nothing about the negligent acts of the other which he has observed or which in the exercise of ordinary diligence he should have observed.

The attending physician is generally not liable for the negligence of an interne, a nurse, or other hospital employee. He is, however, responsible for the acts of the hospital personnel in so far as they are carried out under his immediate supervision and control. Thus, the operating surgeon and not the hospital is held liable for any negligence of operating room attendants during the performance of surgery.

Consent for Operations, Treatment and Autopsies

Consent for operation must always be secured. Any adult in a clear state of mind may authorize operation upon himself. Oral consent might be considered sufficient; but because of the difficulty in proving that it was given, the physician should invariably require a witnessed consent in writing. If the patient is a minor (that is, a person under the age of twenty-one) consent is to be obtained from parent or guardian.[4] If the individual is mentally incompetent, the consent of the one who stands in the position of guardian is required.

When an operation is made compulsory by law (such as vaccination or sterilization[5]) the law furnishes the consent. If an operation is unlawful, consent to the performance thereof does not absolve the surgeon from liability.

In an emergency which demands immediate action for the preservation of the life or health of a patient and in which it is not practicable to obtain his consent or the consent of any one authorized to speak for him, it is the duty of the attending physician to perform without consent such operation as good surgical practice demands.[6]

If sterility is likely to result from the surgery which is contemplated, explanation of that probability should be made and a signed authorization obtained from both spouses. It should be borne in mind that it is hazardous to sterilize any person except upon a positive medical indication. Further, there should be no promise or guarantee that the patient will be sterilized as the result of the procedure undertaken.

The individual physician must secure consent to perform a postmortem examination. This, too, should be in writing[7] and sufficiently comprehensive to allow the removal and taking away of tissue if such is to be done.

The trend of the cases in recent years indicates that it is extremely unwise to pursue a course of treatment in itself hazardous or capable of producing harmful effect without securing a written statement from the patient, or from someone legally responsible for the patient—a statement which clearly expresses understanding of and consent to the special treatment.

Failure to Use Recognized Diagnostic Aids

There are a large number of malpractice actions in the law reports which may be classified under the general heading of "Insufficient Treatment Cases." In every field of medical practice there are cases illustrating "insufficient care": the failure to make a blood count, a Wassermann, a pregnancy test, a culture, a smear, a urinalysis, a stool examination, an x-ray, original or follow-up; failure to make a complete diagnosis or overlooking a reasonably determinable condition; failure to utilize an indicated prophylactic measure (diphtheria, tetanus, etc.); the failure to give instructions, to follow up the original treatment or operation, to institute measures to protect contacts, etc., etc.

Failure to use the x-ray at all, or failure to make sufficient use of the x-ray, has been the chief allegation in many malpractice actions. Whenever a fracture is present which was not diagnosed and no x-rays were taken, the conduct of the attending physician is likely to be condemned as not coming within the standard of good practice.[8] Whenever a bad re-

[4] Statutory exception: In California a female of the age of 18 or more who is or has been married is an adult for the purpose of this consent.

[5] Under Eugenic Sterilization Statutes.

[6] 48 C. J. 1131; Jackovach v. Yocum (Iowa), 237 N. W. 444.

[7] In California, and several other states, it is criminally illegal for any person to perform an autopsy without having first obtained the written authorization of the coroner or other authorized public officer or of the person who has the right of disposition of the body.

[8] "The failure to make use of x-ray as an aid to diagnosis in cases of fracture amounts to a failure to use that degree of care and diligence ordinarily used by physicians of good standing in the community and the court, in absence of expert testimony, may take judicial notice of such fact." Agnew v. City of Los Angeles (Cal.), 218 Pac. (2d) 66.

sult, deformity or limitation of motion occurs, the defense is immeasurably strengthened by the possession of a series of x-rays taken at intervals during the progress of the case. Whenever a patient refuses to have an x-ray made, the physician should fortify himself with the strongest written evidence. X-ray records, as well as the entire case record, should be carefully preserved beyond the time during which a malpractice action may be brought.

The statute of limitations provides the period of time after which specified actions may not be brought. The time provided varies greatly in the several states. A physician should wisely inform himself of the situation in his own state.

Obligations to Patients

To summarize, the physician who would understand his legal obligations, responsibilities, and duties to his patient, must constantly bear in mind the following fundamental obligations:

1. The physician must possess the degree of skill commonly possessed by other reputable practitioners in the same field of practice.

2. He must exercise the degree of care, diligence, and judgment commonly and ordinarily exercised by other reputable members of his profession in similar circumstances.

3. He must keep abreast of progress and follow good practice, common practice, in diagnosis and treatment; he must not experiment.

4. He must not neglect or abandon his patient; he must proceed diligently, without unnecessary delay.

5. He must give his patient sufficient attention and must utilize the indicated diagnostic aids.

6. He must find or anticipate any condition reasonably determinable or reasonably likely to develop.

7. He must obtain legal consent to operate and to perform an autopsy.

8. He must give proper instructions (that is, instructions consistent with the standard of practice) for the care of the patient in his absence, and for the protection of those coming in contact with the patient.

9. He must fulfil the terms of a special contract if he makes one.

The foregoing directions for reducing and avoiding the instigation of malpractice suits will not, of course, guarantee that a physician will not be sued unjustly; for already malpractice may be regarded as a contagious disease of the social body. There are several major reasons for this condition, but two are paramount: (1) the winning of a suit inevitably encourages the filing of others as patients become increasingly "suit conscious"; and (2) such suits are difficult to defend, and the knowledge of how best to conduct such a defense is not sufficiently widespread. The inter-relationship of these two points will be obvious; for each successful defense of an unjust suit will serve as a discouragement to the filing of others. But the second of these causes of high malpractice incidence—the difficulty of conducting a defense—is dangerously enlarged by many physicians themselves. Large numbers of medical men are naive enough to believe that their patients would never file such suits and that no precautions need be taken; and yet such precautions are the only assurance of the best possible defense in the event of a suit. The most vulnerable physicians are those who know that they are maintaining at least an average standard of practice and who are therefore (and blindly) assuming that they will not be sued. This discussion is concerned with *unjust* claims; no doctor who is actually guilty of malpractice should be allowed to go free of penalty. Meritorious claims should be settled out of court—preferably before a suit has been filed.

Prompt Attention Should Be Given to Claims

Another too frequent hindrance to an adequate defense is delay in the investigation of claims; such delay is highly disadvantageous to the preparation of a defense. As a final word of warning that the physician may need every available precaution, one must consider the conditions under which most cases are heard. They are tried before juries made up of lay persons, and it is a truism that no one can say what a jury will do. This is particularly true of malpractice cases, for certainly lay jurors can not be expected to understand complex medical facts. How does a jury arrive at a decision when two expert witnesses testify that the defendant's conduct of the case did not meet the required standard, and two others declare that what the defendant did was consistent with the usual and ordinary practice in the community?

To physicians who have had little or no experience with the law and to lawyers who have little or no medical knowledge, the problem of adequately defending the unjust malpractice case seems insurmountable. And it is true that far too many such cases have been lost simply through poor defense. This is an aspect of the problem which needs a great deal more attention, particularly in areas which have become virtual "hot beds" of non-meritorious malpractice claims. At all times and to all physicians, there should be available expert advice on problems relating to the physician-patient relationship.[9] Whenever a threat is made against a physician, a carefully prepared procedure should be put into effect. Unjustified claims should be contested as thoroughly as possible. In such cases, it is sheer folly to compromise, on the theory that a slight settlement would be less expensive than the cost of defense. Such a course simply serves as an encouragement to others whose claims are not justified. This shortsighted view is largely responsible for the rapid increase in the number of malpractice claims in some sections of the country. If cases based upon unjust or absurd claims are permitted to receive even a slight profitable return, there will be an incentive to bring more of them.

[9] Regan, L. J.: Doctor and Patient and the Law, St. Louis, The C. V. Mosby Company, 1949, chap. 20.

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Be Slow to Compromise

It is a great temptation to a doctor to rid himself of a nuisance claim by making a small settlement. The unfavorable publicity, the loss of time, and the mental and emotional strain involved in defending a malpractice suit may lead the physician to compromise. But, as is so often true, the easiest way out of a situation is seldom the best. For the sake of both himself and his colleagues, the doctor should make a determined opposition to an unjustified claim.

A List of "Commandments" in Malpractice Prevention

In the final analysis, it is the physician himself who is responsible for the continuing existence of the vicious malpractice situation. The physician has generally been satisfied to pay his professional liability insurance premiums and thereafter to sit back complacently, doing nothing until he becomes a target for a malpractice claim. He must be brought to realize that his money payment is only a part of his insurance premium; a much more important part is his contribution of time, of study, and of putting into effect all possible measures to safeguard himself and his colleagues.

Prevention is the best defense against malpractice. Listed below are the 23 malpractice prophylaxis "commandments":

1. The physician should care for every patient with scrupulous attention to the requirements of good medical practice.

2. The physician must know his legal duty to the patient.

3. The physician must avoid destructive and unethical criticism of the work of other physicians.

4. The physician should keep "ideal" medical records in every case: records that would be presentable when offered in court; records that clearly show what was done and when it was done; records that clearly indicate that nothing was neglected and that the care given met fully the standard demanded by the law. If any patient discontinues treatment before he should, or fails to follow instructions, the record should show it; a good method is to file a carbon copy of the letter which advises the patient against the unwise course.

5. The physician should be careful to avoid making any statement which constitutes or which might be construed as an admission of fault on his part. Such an admission, which is usable against the physician, might be made to a third party as well as to the patient at any time before the trial. Such an admission may be made by an agent or employee of the physician during the course and within the scope of the employment. It is important to instruct employees to make no statements.

6. The physician should exercise tact as well as professional ability in handling his patients. A proper professional manner and a sound attitude should be maintained at all times toward both the patient and the patient's family. The attentive physician may early sense some unsatisfactory and disturbing under-current which, by the institution of protective measures, may be prevented from developing into something much more unpleasant. Thus, if the patient is not doing well, consultation may be suggested; if the patient is dissatisfied or complaining, or if the family's attitude indicates dissatisfaction, consultation should be demanded. The use of a consultant affords, in any case, great protection against a malpractice claim.

7. The physician should refrain from overoptimistic prognoses and should avoid promising too much to the patient.

8. The physician should advise his patients of any intended absence from practice and should recommend, or make available, a qualified substitute.

9. The physician should unfailingly secure written consent for operation and autopsy.

10. The physician should carefully supervise assistants and employees and take great care in the delegation of duties to them.

11. The physician should have some knowledge of the statute of limitations and of its significance.

12. In his selection of patients the physician should limit himself to such fields as are well within his qualifications. He should keep abreast of progress in the medical profession.

13. The physician should keep inviolate all confidential communications.

14. The physician should frequently check the condition of his equipment and make use of every available safety installation.

15. In the treatment of the patient the physician must not experiment.

16. The physician must be careful to render sufficient care to his patient in general instructions, frequency of visits, clinical and roentgen ray laboratory investigations and the like. Moreover, every precaution should be instituted for the protection of those caring for the patient and of all other contacts.

17. The patient must not be abandoned. The physician-patient relation can be terminated without liability only in certain ways and under certain conditions.

18. The physician should never reveal that he carries professional liability insurance. Except on the recommendation of his legal adviser, he should never write a letter or make any statement with reference to a malpractice claim. Immediately on being advised of even the possibility of suit, he should consult with his attorney.

19. The physician should arrive at an understanding in the matter of fees. Misunderstanding in this matter, particularly when the question of excessive fees arises, contributes an avoidable element of risk.

20. The physician should secure legal advice if he is called to attend a coroner's inquest as a witness in a case in which he has been in professional attendance.

21. The physician should realize that because of the possibility of error in transmission, it is dangerous to telephone a prescription.

22. The physician should realize that it is hazardous to sterilize any patient except when a medical indication exists.

23. Except in actual emergency, the physician should not examine a female patient unless a third person is present. There is no more serious or destructive charge than that of undue familiarity; and the only way to avoid claims of this sort seems to be to have some one else present during all examinations.

Conclusions

There must be recognition of malpractice as a problem; that the conditions created by it are harmful to the physician and injurious to the public; and that action must be taken to correct it.

The public should be informed as to (1) what constitutes malpractice, (2) how really few cases of actual malpractice occur, and (3) the major degree of responsibility which the individual has in the maintenance of his own health.

Physicians must learn what they may do to safeguard themselves, and must put into effect every possible precaution against an unjust malpractice accusation.

Addenda

I. Consent to Operation

Place _____
Date _____

1. I hereby authorize and direct Dr. _____ to perform the following operation upon me_____
_____
_____
and to do any other procedure that (their) (his) judgment may dictate during the above operation.
2. I understand that the surgeon (surgeons) will be occupied solely with the surgery, and that the administration and maintenance of the anesthesia are independent functions, and will be in charge of Dr. _____ I consent to the administration of such anesthetic, or anesthetics, as Dr. _____ may deem advisable in my case.
3. It has been explained to me that I may be sterile as a result of this operation, although no such result is warranted or guaranteed. I understand what the term sterility means and, in giving my consent to the operation, I have in mind the possibility (probability) of such a result.

A.M. Signed _____
Hour _____P.M. Witness _____

4. I join in authorizing the performance, upon my (husband) (wife), of the surgery consented to above. It has been explained to me that, as a result of the operation, my (husband) (wife) may be sterile.[1]

Date _____ Signed _____
A.M. Witness _____
Hour _____
P.M.

1. Cross out paragraphs not applicable to particular case.

II. Consent to Operation upon Minor

Place _____
Date _____

1. I (we) being the parent(s), guardian, custodian of a minor of the age of ____, do hereby authorize and request Dr. _____ to perform such surgical operation on the person of said _____, a minor, as the judgment of said Dr. _____ may dictate.
2. I (we) also authorize and request the employment of such anesthetic or anesthetics as may be deemed suitable in the judgment of the said Dr. _____, or in the judgment of the anesthetist selected to administer the anesthetic or anesthetics in this case.[2]

2. A similar consent form may, and should, be used in the case of a patient who is incompetent; signed by guardian, custodian, or other person legally responsible for the incompetent.

A.M. Signed _____( )
Hour _____P.M. _____
Witness _____

III. Consent to Observers and/or Photographs and/or Televising

In the interests of science and the furtherance of medicine, I, the undersigned, do hereby consent to and authorize _____ Hospital, and the Operating or Treating Surgeon and such doctors as may be assisting him, to examine and operate or treat me in the presence of other than the usual surgical staff.

I further authorize and consent to the taking of photographs and such subsequent use thereof as may be deemed advisable by said hospital and/or doctor, or doctors.

I further authorize and consent to the televising of any operative or other procedure performed or carried out upon me.

Dated _____ Signed _____
Witness _____ Witness _____

IV. Patient Fails to Carry Out Advice

Note. When a patient neglects or fails to carry out advice, it is desirable to have the facts established in writing. It may be wiser to withdraw from the case (See VII). This is a matter for the judgment of the physician in the particular case.

SAMPLES[3]

3. Substance of letter to patient to be changed to fit the particular facts and circumstances. Carbon copy, with proof of mailing of original written thereon, to be filed with medical case record.

Place _____
Date _____

A.
Name of Patient
Address
Dear Mr. _____:

At the time of my examination of your ankle this afternoon, I advised you of the desirability of having x-rays made. This you refused to do.

Upon your insistence that I treat your ankle and foot, without benefit of x-rays, I agreed to do my best in the circumstances, but as I advised you this afternoon, and must repeat now, I cannot establish, without x-rays, whether or not you have incurred a fracture.

In your own interest, I urge that you have an immediate x-ray study made of your foot and ankle.

Yours very truly,

B.
Dear Mrs. _____:

Upon the history you gave me and my findings on examination, both of this date, I am not able, as I told you at the time of your visit, to rule out pregnancy as the cause of the vaginal bleeding of which you complain.

You have told me that you will not submit to a pregnancy test. I again now advise you of its desirability. I hope you will come in tomorrow morning prepared, as I instructed you, to have the test made. If you continue to refuse to submit to this test, it will be necessary to have a consultant see you tomorrow, if I am to continue to advise you.

Yours very truly,

C.
Dear Mrs. _____:

When, in response to your call today, I saw your husband at your home, I told you my opinion was that he is very seriously ill with pneumonia, and that he should be immediately hospitalized. You refused to permit me to have him removed to the hospital. I told you that I am willing to do the best I can for him under the circumstances, but that he could be better cared for and he would be safer, with less likelihood of complication, in the hospital.

Your husband's condition is such that the matter cannot be discussed with him, so I hope that you will now, after giving the matter more thought, authorize his removal to the hospital.

Yours very truly,

D.
Dear Mrs. _____:

You brought your seven-year old boy in today for me to see. He has a deep, penetrating wound on the sole of his foot, apparently resulting from his stepping on a nail. You thought that it had been received in a neighboring stable.

I advised you that the boy should immediately be given an injection of tetanus antitoxin. You refused to permit me to administer this to him, stating that you had heard of two children who had severe reactions following such prophylactic treatment.

I told you that I would make a preliminary test which would warn us of the likelihood of severe reaction, but that I could not guarantee that result or any result. You reiterated your refusal.

I cannot give the boy this treatment, or any treatment, without your consent. I urgently recommend that you permit me, or some other physician of your choice, to administer a preventive dose of tetanus antitoxin to your boy without further delay.

Yours very truly,

V. Patient Fails to Keep Appointment

SAMPLES[4]

4. When a patient fails to keep an appointment, or discontinues treatment before he should, it is desirable to send him a letter, incorporating the pertinent facts and the recommendations. File a carbon copy, endorsed with a certificate of mailing, with medical case record. Registered mail may be used.

Place _____
Date _____

A.
Name
Address
Dear Mr. _____:

My records indicate that you failed to keep your appointment of _____ (date), and that you have not made any subsequent appointment or appearance in the office.

In your own interest, may I call to your attention the fact that further professional attention is, in my opinion, definitely needed. If there is some reason why you prefer not to return to this office, I urge that you immediately seek other competent professional care. I shall be glad to give the benefit of my knowledge of your case to your subsequent physician, should you elect to receive the needed attention at other hands.

Yours very truly,

B.
Dear Mrs. _____:

You have not returned, as arranged, since, at your request, I examined you on last Friday.

The history you gave of "spotting" between periods over the last several months, and my findings on examination, which I related to you, are of such significance that, as I endeavored to impress upon you when I made an appointment for you to return with your husband, I must urge upon you the advisability of having immediate medical attention.

If you do not wish to return to me, you should consult another physician at once.

Yours very truly,

C.
Dear Mrs. _____:

You failed, again, today to appear in accordance with your appointment at the Radiologist's office so that a check-up x-ray could be made of your fractured wrist.

I have previously urged upon you the necessity of having your cooperation to improve the likelihood of a favorable result.

You should not be heard to complain of the end result, if it is not satisfactory, when you refuse or neglect to follow the advice of your physician.

I now request that you appear at my office at ten o'clock tomorrow morning. I am arranging to have x-rays made at that time and to have a specialist in orthopedic surgery see your arm.

Yours very truly,

VI. Patient Discharges Physician From Case[5]

5. If a physician justifies his failure to continue in attendance upon a patient upon either his having withdrawn from the case or of having been discharged by the patient, the burden of proof of such contention is upon him—hence the desirability, if not the actual necessity, of having written evidence available.

Dear Mr. and Mrs._____:

This is confirmation, and my acknowledgment, of the fact that you have, as of this date, discharged me from further professional attendance upon you in your current illness.

Should you desire, I shall be glad to cooperate with the physician you now call, in supplying him with such information as I have gained in respect to your case.

Yours very truly,

VII. Physician Withdraws From Case

Note. A physician may withdraw from attendance upon a patient, but he must give reasonable notice of his intention to do so and must allow the patient reasonable time and opportunity to fill his place. If the fact, whether a physician did withdraw from professional attendance upon a patient, became an issue in the case the burden of proof falls upon the physician. For this reason, it is desirable that written evidence be available.

It is a serious question of judgment, whether, when a patient fails to cooperate or refuses to follow advice, the physician should continue on the case. It is recommended that, if the physician decided to continue to care for an uncooperative patient, who, for example, refuses to have an indicated x-ray study made, he should demand and require consultation.

SAMPLES[6]

6. Letters should be sent and carbon copy filed. The wording should be simple and direct, but the intent and meaning must be clear and certain.

Place _____
Date _____

A.
Name
Address
Dear Mr. _____:

You have repeatedly failed to follow my advice and recommendations.

I am therefore advising you of my intention to withdraw from further professional responsibility in connection with your case. To allow you a reasonable opportunity to secure another physician, I shall be available, at your request, to render you service for three days from your receipt of this letter, but not thereafter. In this period of time, in this community of several hundred physicians, you can readily fill my place.

I shall be glad to give, to any reputable physician of your choice, the benefit of such knowledge as I have gained of your case.

Yours very truly,

B.
Dear Mr. _____.

You consulted me this afternoon in connection with an injury to your foot and ankle. At that time, upon your refusal to have x-rays made of the injured area, I advised you that I could not undertake to render professional service to you.

So that there may be no misunderstanding, I am confirming these facts in writing.

Yours very truly,

C.
Dear Mrs. _____:

As I told you this morning, I cannot longer continue to be professionally responsible for the care of your little boy. This decision is necessitated by the fact that you have repeatedly refused to permit me to make the detailed and thorough study of his condition which I regard as indicated and vital.

Please secure other medical attention at once. In the meantime, and for a reasonable time, I shall remain available, at your request, to render any routine or emergency service that may be required.

I shall, of course, be glad to offer to Tommy's new physician the knowledge of his case which I have been permitted to acquire.

Yours very truly,

D.
Dear Mrs. _____:

You failed to keep your appointment this week.

At the time you received your injection last week a portion of the needle broke off in your tissues. You were at once advised of this accident. As I told you, after preliminary search, I was unable to recover the broken piece without anesthesia and incision, and recommended that localization studies be made prior to undertaking definitive search.

I again recommend that procedure and will make arrangements at your request and responsibility.

Yours very truly,

Physicians and Child Placement

THE Attorney General, in an opinion to the Wisconsin Department of Public Welfare, concluded that a physician who assists in, or arranges for, the placement of a child by its parent or guardian in the home of a stranger, violates the Wisconsin Statutes. Illustrative cases are set forth and considered in the Opinion, and indicate the extent to which a physician may properly act in this field. The Attorney General's opinion may be found at 37 O.A.G. 403.

Illustrative Cases

"A. The physician who confined Miss A, an unmarried mother, learned that she had expressed a wish to place her child for adoption. He therefore informed Mr. and Mrs. Y, who were patients of his, that he knew of a child that would be available for adoption. He gave the name of the adoptive parents to the mother. They made arrangements to transfer the child to them upon discharge from the hospital. The adoptive parents sent a relative to meet the mother outside the hospital and the relative transported the child alone to the prospective adoptive home.

"B. The physician who confined Miss B, an unmarried mother, learned that she had expressed a desire to place her child for adoption. The physician told the mother that he knew a desirable adoptive home. He communicated with the proposed adoptive family, telling them about the child and suggesting that they employ an attorney. Subsequently the attorney visited the mother and obtained the mother's consent. Upon discharge from the hospital the mother and child were met by the adoptive parents who took the child to their home.

"C. A nurse employed on the staff of the hospital where Miss C was confined, learned that Miss C wanted to make an adoptive placement of her child. The nurse talked to Miss C and informed her that she knew a family who would be interested in adopting her child. She also informed the family about the child and suggested that they come to the hospital to see the baby and to talk with the mother.

"D. Miss D informed her physician that she wished to place her child for adoption. The physician informed her that he knew families who wished to adopt and offered to take the baby and place it in an adoptive home. Miss D consented to this and the physician took the baby to the adoptive home.

"E. Miss E informed her physician that she wished to place her child for adoption. The physician told Miss E that he knew of a good home for the child. Miss E stated that because of her confidence in the physician she would place the child with anyone he recommended. The physician then informed the prospective adoptive parents and suggested that they employ an attorney. They conferred with an attorney, informing him that they had received information from the physician about a child that was available for adoption. The attorney conferred with the mother and arranged through the physician's office to personally take the baby upon the mother's discharge from the hospital. Thereafter, the attorney personally took the baby from the mother and delivered it to the adoptive parents. The attorney justified his actions on the grounds that he deemed it a desirable service to his client to prevent the mother from learning the names of his clients and to prevent the clients from learning the name of the mother. It was the position of the attorney that the mother had made the placement and that he had nothing to do with the actual placement as distinguished from the adoptive proceedings. You inquire whether the attorney violates section 48.37 (1) in that he "assists" in the placement.

"In case A it is our opinion that on the narrow fact situation presented no successful prosecution could be maintained. While it could be argued that one who gives information gratuitously to the parties performs a material act of 'assistance,' it is our view that unless more could be shown it would be impossible to obtain a conviction. If the physician, in addition to informing the prospective adoptive parents of the existence of the child, actively promoted the placement, there would be a clear violation. But just passing on the information is insufficient in our judgment to warrant a prosecution. The doctor could always say that nothing he did prevented the parties from using proper channels in obtaining the placement. Nor was the act of the relatives in taking possession of the child for the adoptive parents, after the arrangements had been made, sufficient in our judgment to warrant prosecution.

"In case B it is also our view that the physician should not be prosecuted for merely giving the information, particularly since he suggested employment of an attorney. The attorney, according to the facts stated, merely performed a legal service in obtaining the mother's consent and did not 'assist' in or 'arrange' for the placement in the sense meant by the statute.

"It should be repeated, however, that in both cases A and B if additional facts were shown there might well be grounds for prosecution.

"In case C it does not appear that any placement was made, but the nurse informed the mother that she knew of a family who would be interested in adopting the child, and also told the family about the child and suggested that they come to the hospital. Her conduct was not such as to violate section 48.45 (1) because it does not go so far as

to constitute a representation that she was *able to dispose of* the child.

"Case D is a clear violation of section 48.37 (1) since the physician did everything necessary to the placing of the child.

"In case E the physician knew that his recommendation would be followed because of the mother's confidence in him. It seems that he did more here than in either case A or case B. It would appear that he *recommended* the prospective foster home. If so he 'assisted' the mother in placing the child by making such recommendation and by putting the parties in touch with each other, notwithstanding his suggestion that an attorney be employed. The attorney also clearly 'assisted' in and 'arranged' the placement. His attemped justification is not valid, since he did more than perform a legal service. His theory would result in exempting attorneys altogether from the application of sec. 48.37 (1). Such exemption was not put in the statute by the legislature and cannot be read into it by implication."

The Attorney General, in the same opinion, discusses the reasons why the state itself, or through its licensed private agencies, has undertaken to perform the function of child placement.

"Experience has shown that so-called 'irregular' placements do immeasurable harm in many respects. They have come to be known popularly as constituting a 'black market' in babies. Even the most well-intentioned persons usually lack the necessary training and are unable or unwilling to make the necessary investigation to determine whether a particular placement is in the best interests of the child. Sometimes, not always, pecuniary matters are permitted to outweigh considerations of the child's welfare, as when the prospective foster parents agree to pay the lying-in expenses. But even in cases where that element is lacking, a great deal of mischief may result. The prospective foster parents may find later that the child has physical or mental defects or conversely the foster home may not be suited for the child. It may happen, too, that proper legal steps to terminate the rights of the natural parent or parents or to obtain their consent to an adoption have not been taken and later on the natural parent or parents cannot be located, or even in some cases identified."

PHYSICIANS WARNED ON SUBSTITUTION OF SILVER NITRATE

Attention has been directed to the fact that some Wisconsin physicians are reporting on birth certificates the use of penicillin as a substitute for silver nitrate in the prevention of opthalmia neonatorum. While there has been some discussion in professional circles regarding the efficacy of substitutions for silver nitrate, the Committee on Maternal and Child Welfare has expressed the opinion that to date there is insufficient evidence to support such action. Physicians are urged to subscribe to the procedures clearly set forth in the Wisconsin Statutes, which reads:

> "146:01 **Infant Blindness:** (1) For the prevention of opthalmia neonatorum, or blindness in the new born babe, the state board of health shall, annually, cause to be prepared and put up in proper containers a one per cent solution of nitrate of silver with instructions for its use. These shall be distributed free to local health officers in quantities sufficient to enable them to, and they shall, deliver one to each physician and midwife. The attending physician or midwife shall use the said solution as directed in said instructions.
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> * * *
>
> "(3) Any person who violates this section shall be fined not more than one hundred dollars."

On the basis of present procedures set up through the State Board of Health, and the reliable services of the State Laboratory of Hygiene in supplying solutions of correct strength and freshness, it does not appear advisable to the Committee on Maternal and Child Welfare to suggest revision of the Wisconsin statutes at the present time.

Until such time as the wording of the law is changed, physicians are warned to avoid the use of any substitute for silver nitrate in the prevention of opthalmia neonatorum, as violation of the statutes subjects a physician to a possible fine, as indicated, and may subject him to a suit for malpractice.

The position adopted by the committee concurs with that of the American Medical Association as was stated in an editorial which appeared on page 123 of the January 12, 1952, edition of the Journal of the American Medical Association.

Disability Evaluation

By CHESTER C. SCHNEIDER, M. D.
Milwaukee

DISABILITY evaluation is not an exact science resting on mathematical rules which will inevitably produce the same conclusion irrespective of who operates the formula. The conclusions reached vary with the evidence and the significance attached to it, the previous experience of the expert, and the condition and reaction of the patient. Given the same facts, even conscientious experts can disagree about their significance, so the disagreement between experts does not imply dishonesty or incompetence on their part.

Appraisal of injuries and their immediate and future disability producing potentials is a complicated and important subject. It requires extensive knowledge of all diagnostic procedures necessary to evaluate the exact nature of the injury and the probable consequences of natural healing and degenerative changes over the remaining life of the patient. The expert must study the problem with an open mind, determined to assemble all the facts necessary for the establishment of a correct diagnosis and a fair and complete comprehension of all relevant matters. Too often prejudicial factors resulting from biased attitudes, limited and unbalanced experience, preliminary prejudicial conferences with lawyers or adjusters, too zealous a desire to be helpful to the interests being served, and hostile or ingratiating patient attitudes consciously or unconsciously channel the conclusions which he reaches. This is particularly true where the objective findings are in contrast with the subjective complaints and frequently accounts for the wide disagreement between otherwise honest and sincere experts.

After accurately assembling all the necessary information required to establish a diagnosis and to form the basis for an opinion, the expert must prepare a report which is clear, concise, adequate for its intended purpose, unpadded with unnecessary and irrelevant data and narration, and completely understandable. The preparation of an entirely satisfactory report is an art which every physician should assiduously practice throughout his career. He must bear in mind that the report is his sole agent in these matters and, if it does not impress the reader as being neat, thorough, well prepared, and understandable, it will fall short of its objective. The physician should know what is to be said and say it as clearly and briefly as possible. He should also put enough punch into his opinion to reflect solidity of character, and he should rest his conclusions on facts, accurately established, clearly set forth, and logically evaluated.

Traumatic situations in general may be subdivided into four large groups:

1. Those with no objective evidence of injury and no underlying defects or disease of antecedent origin.

2. Those with no evidence of injury but with underlying defects or disease of long standing.

3. Those with evidence of injury and no associated antecedent defects or disease, and

4. Those with evidence of injury and also with associated long standing defects or disease.

Obviously each of these groups requires different analysis and leads to divergent conclusions.

In Wisconsin and other states, helpful basic tables have been prepared by the Industrial Commission to guide the physician in estimating disability; these should be studied. They set forth the value of amputations at all joints of the extremities, the relative loss of function due to complete and partial loss of motion at each of these joints in various positions, the value of partial and complete loss of sight and hearing, and the disability due to reduction of length of the lower extremities. Through the aid of these tables, even defective conditions not included can be appraised by computing their disabling effect in relation to the tabulated conditions. The disability may vary according to special features that produce functional loss. Pain, loss of sensation, weakness, mechanical disadvantages, and reduced endurance must be added to disability for limitation of motion.

Every physician is perplexed and frequently confused by the patient with many complaints unsupported by objective evidence of recent injury and no antecedent disease. These purely subjective situations cause conflict of expert opinion. The conscientious expert must support his conclusions by substantial findings, and consequently his position becomes untenable when he assumes the existence of pain and disability without objective defects to explain them. Cautious and well trained experts will not allow themselves to be misled by the patient whose symptoms will vanish after the litigation has terminated. In these cases a conservative and reasonable attitude is safest, and the expert will do well to confine himself to a statement of the complete absence of objective findings, if that is the case, and to an opinion as to the existence of the alleged dysfunction and pain under the existing circumstances. It must, of course, be conceded that pain and disability can exist without detectable physical findings, and the expert must be aware of these possibilities and qualify his statements accordingly.

Injuries which disturb the circulation of vital structures often lead to slowly evolving defects which cannot be detected for months or years after the accident. Disc injuries in the neck or lower back, damage to articular cartilages in various joints, damaged nutrition to small bones of the wrist, and many other similar conditions are almost impossible to detect in their early stages and require careful investigation to diagnose. Until the tell-tale signs and symptoms of late degeneration appear, the expert can only suspect the underlying situation and advise delay in the final disposition of the matter.

Many cases of alleged disability following accidents occur in individuals who show no evidence of traumatic structural defects but in whom more or less advanced pathologic conditions of long-standing can be found. These include architectural defects of developmental or congenital origin which can easily be rendered symptomatic by an accident, even though they had been completely silent prior to that time. Structural defects in the lower back are peculiarly prone to become symptomatic after sprain, and it is amazing and disconcerting to note how unresponsive to normal healing such injuries can be. Chronic arthritis is another condition which may smolder silently for years only to be rendered painful by some relatively minor injury. Symptoms which may have been present but disregarded by the patient for a long time suddenly assume striking importance and cause great annoyance after a compensable accident. Grating or grinding of the bones in the neck is a most common phenomenon in middle-aged and elderly people, rarely causing apprehension or inconvenience until some slight accident has occurred, and then the patient regards the same symptom as proof of a serious injury with permanently disabling potentialities. Many people forget, or have learned to disregard, the consequences of an old non-compensable injury until the same area is reinjured under compensable circumstances. Then all the effects of the ancient injury are suddenly attributed to the recent one. In such instances the expert must exercise great care to segregate the old from the new.

Traumatic aggravation of chronic smoldering disease most certainly can occur. Influences inadequate to injure normal tissues can affect defective ones. These reactions are usually persistent and do not respond to treatment. They must be recognized and appraised in accordance with the experience of similar cases.

Injuries of the back have long been known for their difficulty of determination and evaluation. "Railroad spine," "sacro-iliac sprain," and more recently "disc lesions" have successively plagued the medical profession. This is due to the great frequency of injuries to the spine, the complicated anatomy of this region, and the relative ease of misrepresentation of symptoms which they permit. Often they do not disclose themselves by definite, objective signs. Even the x-ray and other special diagnostic facilities cannot always reveal evidence of injury. Consequently appraisal of injuries of the spine requires not only the most conscientious and searching investigation of the patient, including many special diagnostic methods, but demands also careful observation of the patient himself and his reaction to many special tests. In one way or another every tissue under suspicion can be subjected to investigation, and the complex picture of actual injury recorded. If the findings are consistent and logical, the conclusions are definite and irrefutable, but if they are confused and inconsistent, they arouse suspicion and doubt.

Injuries of the spine have strikingly contrasting potentialities. A wrenched neck may merely stretch a muscle or ligament causing only temporary discomfort and no permanent residuals or, it may fracture an intervertebral disc and lead to interminable trouble. A "broken back," so-called, may be only a cracked appendage of one of the vertebrae, or it may be a crushed vertebral body with or without paralysis from injury of the spinal cord. A "low back strain" or sprain may be a minor muscle stretch, or it can be a ruptured intervertebral disc, with or without protrusion of disc material into the spinal canal. This latter condition can, and frequently does, lead to chronic changes in the disc, maladaptation of the vertebrae to each other, instability of the lower spine, chronic back ache, sciatic nerve irritation, and even partial paralysis. All of these conditions can be diagnosed by careful examination including the use of x-rays, spinal puncture, injection of oil or air into the subarachnoid space, and special physical and laboratory tests. If an injury actually has occurred, the expert by means of a competent examination will be able to find evidence of it. If he does not obtain conclusive evidence of an injury or if the findings are inconsistent, he is justified in presuming that no abnormality is present. Often the patient's unsupported allegations represent only a part of the picture of his insincerity and unreliability.

Another feature of the spine which often leads to confusion is the presence of structural defects of congenital or developmental origin, which closely simulate those caused by trauma. Thus, wedge-shaped vertebrae (Scheuermann's Disease, Calve's disease, hemivertebrae, etc.), unattached portions of vertebral bodies (limbus vertebrae, unattached transverse spinous processes, unattached articular processes, etc.), unfused interarticular portions of vertebrae (spondylolysis, etc.), and many other defects may either be the result of congenital or ancient acquired abnormality or recent trauma. The physician who wishes to qualify as an expert must be able to differentiate these conditions.

Wills For Physicians*

By HON. WILLIAM F. WAUGH
Judge of the Probate Court of Cook County, Illinois

Probate Judge William F. Waugh was invited to write this article because he is recognized as one of the nation's outstanding authorities on the subject. He presides over "the world's busiest court," so characterized because it deals with a larger volume of legal business than any other court presided over by a single judge. This vast legal traffic is concerned principally with administration of estates, whether or not a will has been made.—ED., *Journal of the American Medical Association.*

Introductory

THERE is a widespread superstition which deters many persons from practical consideration of the question "What will be done with my property after my death?" The superstition seems to be that making a will is an invitation to fate to strike one down. It is difficult to believe that physicians, whose professional duties require a sensible attitude and intelligent philosophy on the ever present matter of life and death, could be among the superstitious. Whatever the reason, the evidence indicates that physicians are certainly among the many who fail to make necessary provisions for distribution of their hard-earned possessions when the inevitable occurs.

Indeed, physicians were counted "present" when a recent survey disclosed that 60 per cent of the decedents whose estates were probated in the Probate Court of Cook County in the last 20 years failed to leave wills. The result was that the estates of all these persons—money and property which they had accumulated in a lifetime of effort—descended to and were arbitrarily distributed among their heirs at law in accordance with the statutes of the state of Illinois.

In many instances that distribution was contrary to the wishes of the decedent, worked a hardship on the members of his immediate family, entailed unnecessary expense and provided windfalls for relatives who had contributed nothing toward its accumulation and who may have been wholly unknown to the decedent. The harsh and often inequitable disposition of one's assets at death may be avoided by the simple expedient of making a will.

Will a Privilege; Technical Requirements

Just as society makes the laws which provide rules of conduct in daily life, so, too, society has devised the method by which one can dispose of one's worldly goods. It is only logical that the laws —statutes in the various states—recognize that "blood is thicker than water." Frequently a person, for any number of human reasons, wishes to bestow on someone unrelated by blood a good part, a small part or all of his wealth. But the law cannot know the reasons or even the desire to do so. Only the fact of blood kinship can be considered when it is left to the law to make a distribution.

What must be clearly kept in mind, therefore, is that making any disposition of property other than by the law of descent is a privilege which must be acted on. The instrument by which this may be done, and which is recognized by the law, is the will, or "testament." The law describes how a will must be executed and requires strict compliance. Hence a will is a written instrument by which one makes a disposition of property to take effect after death, within the limits fixed by the statutes of the several states. The testator (maker of the will) may dispose of his property by will to whom he pleases, limited only by the rights given by law to a surviving husband or wife.* He may disinherit any or all of his blood relatives, even his children, no matter how unjust his exclusion of his heirs may be, and he may give his property to a stranger to his blood.

Anyone who has attained his or her majority and who is of sound mind and memory may make a valid will. The will must be in writing and executed in accordance with the requirements of the state law. It may be changed from time to time by the testator through the making of a codicil or an entirely new will. A codicil is an addition, or supplement, and is usually amendatory or explanatory of the original document. It is a part of the will and must be executed with the same formality as a will. The use of the codicil often results in contradiction and confusion. Consequently, when changes are desired the execution of a new will is recommended. (Other pertinent definitions: An executor is the person who is named by the testator to execute the provisions of his will. An administrator is the person named by the court to administer a decedent's estate when there is no will.)

Making a will requires more than merely writing out intentions, if one really wants to have one's wishes carried out. Its language must be clear and unambiguous, and it must be executed in accordance with the law. In preparing and executing it one should have the assistance of a competent lawyer,

* *Editor's Note:* In Wisconsin except where there has been an ante-nuptial agreement, a widow may elect within a year of her husband's death to take a one-third interest in her late husband's estate, instead of taking under his will. A widow will not ordinarily take this step unless her husband's will leaves her less than a one-third interest, or unless it establishes a trust which she deems undesirable.

* Reprinted, with permission, from the Journal of the American Medical Association, November 4, 1950.

and this is certainly one instance where, I believe any physician would agree, "an ounce of prevention is worth a pound of cure." Many a physician who is aware of the hazards in a layman's self diagnosis fails to recognize the analogous pitfalls in his acting as his own lawyer. In the field of law he is no longer a professional, he is a layman.

Planning a Will

A will should be well planned, clearly written, revised from time to time to keep it up to date, and placed where it can be found when needed. I would suggest the following procedure as a well ordered course:

Prepare a memorandum containing a list of your assets, including all assets associated with your medical practice, how you desire to dispose of them and a list of your nearest relatives, together with their last known addresses. . . . Then see a lawyer, present the memorandum to him and tell him what you want to accomplish. He will bring to your attention the necessity of naming an executor. . . . He will also point out the desirability of requiring a surety bond as a protection against avoidable loss, unless the surviving husband or wife or some other equally trustworthy person is to be named. In such cases it is customary to provide that he or she be authorized to act on the filing of a personal bond with surety waived. The lawyer may point out the advantages of naming a bank or trust company as executor, since the experience and judgment of their trust officers, coupled with the fact that they are impartial and will deal objectively with any situation that may arise, recommend their appointment. He will also inquire as to what provision, if any, you have made for the payment of federal estate and state inheritance taxes, which may be assessed.

Holding Down Tax Liability

At this point it is well to know that in these days of high taxes and involved tax laws the preparation of a will by an expert may result in substantial savings in taxes, leaving more of the estate to be distributed. An example of possible saving in taxes is provided by the marital deduction provision in the Revenue Act of 1948. The requirements for qualifying a bequest to a spouse as a marital deduction are technical and require the help of an expert.

When the will is drawn, provision should be made to meet payment of federal estate and state inheritance taxes. There are many tragic instances in which failure to plan necessitated sale of assets at a sacrifice for the satisfaction of tax claims.

Remember, too, that your will can become out of date unless it is revised from time to time. Personal relations change, children are born and sometimes beneficiaries named in your will die before you do.

Keep Will Safely

Finally, make certain that the will is kept in a place where it may be quickly brought forward when it is needed. Leaving it with the lawyer or bank or trust company is recommended, or it may be placed in a safe deposit box. In any event, keep it in the place where you have your insurance policies, title papers and other valuable documents, and let someone you trust know of its existence and whereabouts.

It is apparent that the making of a will involves a careful planning of affairs and is not merely making a disposition of assets effective after death. A man and wife approaching the making of a will with proper planning gain a whole new conception of their affairs and take steps that are to their advantage during their own lifetime, such as placing the family bank account and title to the home in their joint names, in addition to providing safeguards and benefits for their prospective survivors.

When death occurs and a will has been properly made, the survivor or survivors are then obliged to have the will recognized by the law and its provisions carried out. The widow, or someone acting for her, should immediately contact the family lawyer, turn the will over to him and be guided by his advice.

Difference Between Leaving and Not Leaving a Will

Everyone should make a will. When a man dies without having made a will, the law makes one for him. The following case, I think, indicates plainly some additional advantages of making a will.

A man has an estate of $50,000. He has a wife and two minor children. His will states that he wishes all his property to go to his wife, and that he is making no provision for the children because he is fully confident that she will provide care and education for the children from the money he is leaving. He names her as executrix and stipulates that she act on her personal bond without surety. When the lawyer presents the will to the court, the administration of that estate is relatively expeditious and inexpensive.

In a similar case, but one in which the man does not leave a will, the law decides the manner of distribution. . . . One third of the estate after expenses and debts are paid goes to the widow; the remaining two thirds go in equal parts to the children.* Immediately, the law sets up a variety of

* *Editor's Note:* Where a widow and only one child survive, the widow takes one-third of the real estate, but one-half of other property. Widow's rights in the homestead are exclusive of the above, and continue until her remarriage or death. They consist of a right of occupancy, or the right to the income from its rental; also a right to one-third of the proceeds should the homestead be sold.

Should no child survive, and the husband leave no will, the widow takes the entire estate under Wisconsin law.

safeguards. The widow is entitled to be named as administratrix, but she must provide bond with surety. This usually means a surety company bond, for which a premium is paid. Next, an estate must be opened for the minors and a guardian appointed. The widow may be appointed guardian of her own children, but again she must provide a surety bond and pay a premium. In addition, the children's share must be deposited in the minors' estate; it cannot be used except for the care of the minors and may be withdrawn only on approval of the court. This means that every time a withdrawal is to be made and the money is to be used by the widow petitions must be filed and presented to the court, entailing the employment of an attorney and involving various court charges. It can easily be seen that failure to make a will in the circumstances set forth above involves the widow in burdensome legal duties together with extra expenses.

It is perfectly proper for a man to set up any number of controls within the limitations of the law for his children or for strangers or for anyone else he wishes to share in his estate. That is entirely his business, but he must make it his business, through execution of a will c l e a r l y setting forth his desires. . . .

Delays May Be Costly

More than 30 per cent of all wills are drawn during the year prior to death. This means that a great many wills are drawn in haste or at time of unusual mental or physical stress or illness. These and the ones in which the makers lacked testamentary capacity, or have been subjected to undue influence, are the wills that are constantly being broken or which lay the foundation for long drawn-out and expensive legal battles. Certainly making a will should be the careful and considered act of every man and woman who respects human and economic values. It should be undertaken when a person is in good health and of sound mind, when he is motivated by the wish to implement the right of personal judgment, reflecting the love he bears for those closest to him.

BENEFITS OF THE 1950 SOCIAL SECURITY LAW CHANGES TO THE DOCTOR

Self-employed doctors are specifically excluded from the 1950 Amendments to the Social Security law which brought within Social Security most other self-employed persons.

Doctors and nurses who are employed by organizations organized for profit have been covered by social security all along. Doctors and nurses employed by nonprofit organizations may now be covered provided the employer waives its statutory exemption and two thirds of its employees sign a statement asking to be covered.

Of particular importance to the many doctors and nurses who served in the Armed Forces in World War II are the "new start" provision and wage credits of $160 per month given for every month of active military service between September 16, 1940, and July 24, 1947. Under the "new start" provisions, a person is covered if he has worked in a covered job one-half the time *after* 1950 until age 65 or death. Moreover, the coverage he acquired at any time, including the coverage earned in the Armed Forces in World War II, since the original social security law went into effect in 1936, may be used as coverage after 1950.

For example, assume a physician, who has been in private practice since 1935 but who spent three years in the Armed Forces during World War II. He is now fully insured and will continue so until the end of 1956. His family, should he die before the end of 1956, has insurance protection under the social security law because his three years military service give him six years protection.

A person becomes permanently insured and covered after ten years covered work earned at any time after the original social security law was passed.

Benefits payable have been substantially raised to conform more with the current cost of living.

The law continues the provisions entitling covered workers and their wives to benefits upon reaching age 65, as well as the benefit payments to widows as long as she has minor children in her care.

As an employer, the maximum of taxable wages paid to employees to be reported has been raised from $3,000 to $3,600 annually, effective January 1, 1951.

State Board of Health Services and Communicable Disease Rules

MEMBERS OF THE WISCONSIN STATE BOARD OF HEALTH. Seated, left to right: Stephen E. Gavin, M. D., Fond du Lac, president; Carl N. Neupert, M. D., Madison, secretary; Samuel Heuke, M. D., Eau Claire, vice-president; Stephen Cahana, M. D., Milwaukee; Carl D. Neidhold, M. D., Appleton. Standing, left to right: W. T. Clark, M. D., Janesville; Forrester Raine, M. D., Milwaukee; Woodruff Smith, M. D., Ladysmith; and E. H. Jorris, M. D., Madison, assistant state health officer.

AN OVER-ALL VIEW

THE State Board of Health determines policies for the administration of the department and adopts rules and regulations pertaining to its statutory functions. This board consists of seven members appointed by the governor and confirmed by the senate for seven-year terms. The Board selects its own secretary, who is also the state health officer.

The work of the Board and of the department under its jurisdiction is supplemented by local boards of health and health officers in all towns, villages, and cities of Wisconsin. To assist in any local problem that may arise, the State Board keeps in constant touch with local boards and health officers through its district health offices.

With funds made available through the United States Public Health Service and the Children's Bureau, it has been possible to enlarge the work of the State Board of Health in tuberculosis control, venereal disease control, cancer control, maternal and child health, industrial hygiene, nutrition, mental health, and hospital construction.

The various bureaus, divisions, and units of the department are organized on a functional basis. They fall into five main sections: General Administration, Preventable Diseases, Environmental Sanitation, Maternal and Child Health, and Local Health Administration. The activities of each division or unit are described very briefly on the following pages.

FUNCTIONS AND ACTIVITIES

Section on General Administration

General Administration is concerned chiefly with the coordination of activities for the entire department. It does, however, direct the duties of the following divisions.

Division of Personnel represents the State Board of Health with the Bureau of Personnel on all matters related to the recruiting, selection, classification, promotion, dismissal, etc., of employees of the department, including the Wisconsin State Sanatorium and Lake Tomahawk State Camp, numbering approximately 450 employees; where requested,

studies, analyzes, and makes recommendations on matters related to internal office procedures and techniques and recommends revisions in organization structure or complement; on request, conducts surveys for local full-time health departments to establish appropriate salary schedules and classification systems and submits recommendations calculated to improve the effectiveness of office management and personnel utilization; and assists localities on request in the recruitment of personnel in categories where the market is in short supply.

Division of Budget and Accounts prepares state and federal budgets, payrolls, and audits expenditures for all funds; estimates receipts and expenditures for inclusion in request to the state legislature for funds; maintains records of all appropriations, allotments, and receipts and expenditures of the department and those covering the state tuberculosis sanatorium at Statesan and the Rehabilitation Camp at Lake Tomahawk. In addition, it audits the reports of the county tuberculosis sanatoria for payment of state aid.

Division of Laboratories—Public health laboratories are operated at Madison, Beloit, Green Bay, Kenosha, La Crosse, Oshkosh, Rhinelander, Sheboygan, Superior, and Wausau. These laboratories are established to perform bacteriologic, microscopic, and chemical examinations of specimens from persons suspected of diseases or of milk, water, or food for the primary purpose of protecting the health of the public.

Some of the specific tests conducted are those to detect the presence of tubercle bacilli, gonococci, meningococci, typhoid and paratyphoid organisms, and ova and cysts of parasites; and those to detect diseases such as rabies, actinomycosis, tularemia, and undulant fever. The laboratories also prepare typhoid and paratyphoid vaccines and produce other biologic agents which may be used in the control and prevention of disease. These tests are made for licensed physicians, veterinarians, health officers, and health commissioners without charge.

Bureau of Vital Statistics keeps the official, permanent record of all births, stillbirths, marriages, divorces, and deaths, and tabulates the official data on these records in conformity with the rules governing the International Registration Area. For a nominal fee, partial or certified copies of these records can be obtained upon request. The standard forms for reports are issued and frequent tests conducted to determine the completeness of registration. (See chapter 69—1947 Wisconsin Statutes.)

Microfilm laboratory produces microfilm and photostats of birth, death, and marriage certificates or other material as required by the Board of Health, and furnishes any of these services at cost to other state agencies. X-ray films from the state mobile x-ray units are also processed.

Division of Dental Education plans and directs a state-wide program of dental health education and research; conducts controlled studies of the effects of fluoridation of water in the prevention of dental caries; and at present is demonstrating the topical application of fluorides to teeth in certain areas in the state.

Division of Health Education provides special assistance in health education activities for all sections and the district offices; promotes and develops health education activities in local health departments and in official and non-official agencies interested in health.

Movies, slides, exhibits, and filmstrips on health subjects are loaned to schools, public health agencies, clubs, and other groups throughout the state.

Articles on health subjects are prepared and submitted to the Wisconsin press. The bimonthly bulletin, "Health", the Biennial Report, and other reports are edited, and pamphlets are prepared.

Health educators with special training in sex education assist communities in the development of local social hygiene programs. They help schools in integrating social hygiene into the curricula and lead discussions with boys and girls.

In cooperation with safety councils publications, visual aids, and other materials on home safety are made available to local communities to use in developing their own programs for the prevention of home accidents.

Division of Hospital Survey and Construction inventories existing hospitals (general and allied, chronic disease, mental, tuberculosis sanatoria, public health centers, and related facilities), including public, non-profit, and proprietary hospitals; surveys the need of such public and other non-profit hospitals as will afford the necessary physical facilities for furnishing adequate hospital, clinic, and similar services to all of the people of the state. The state act has set up an advisory hospital council to assist and consult in the development of the state plan.

Approximately 60 per cent of the federal funds are allocated for general hospital facilities; the remaining 40 per cent for other categories of facilities. The plan establishes a list of priorities for 66 areas of the state for the approval of general hospital projects. The order of priority is based primarily on the relative need for hospital facilities, although special consideration is given to rural areas and areas with low financial resources. The approval of facilities other than general hospitals is made by the State Board of Health within an order of priority determined from year to year. It is based upon the number and type of applications on file and the need which exists for these specific projects from the area of application. Applications are received up to and including the beginning of each fiscal year, starting July 1. Projects are approved shortly thereafter within the limitation of federal funds available. Thirty-three projects have already received initial or final approval during the first five years of the program. Twenty-eight are for 1,127 general hospital beds. The remaining seven are for other categories: chronic disease, one; psychiatric, two;

combination chronic and psychiatric, three; and a new state laboratory of hygiene building. The 33 projects have absorbed all of the federal aid available during the first five fiscal years of the program.

Wisconsin's share of the annual federal allotment amounts to approximately $1,500,000. The state plan provides that 55 per cent of the construction costs be borne by the applicant. Applications for federal grants-in-aid and other detailed information may be obtained from the State Board of Health, Division of Hospital and Related Services, State Office Building, Madison 2, Wisconsin.

Nursing Homes. The division is responsible for the registration, licensure, inspection, and regulation of nursing homes, including boarding and convalescent homes for the aged, infirm or chronically ill, proprietary, nongovernmental or governmental, except county institutions subject to the supervision of the State Department of Public Welfare under sections 46.16 (1) and 46.17 (1) of the statutes.

The advisory committee consists of the state health officer and the director of the department of public welfare, or their designated representatives, and seven additional members including persons of recognized ability in the fields of hospital administration, nursing home operation, medicine, nursing, social services, and persons with broad civic interests representing the general public. The committee advises and consults in the establishment and review of minimum standards and rules and regulations for such homes.

License is required for the reception and *care or treatment* not less than 72 hours in any week of three or more *unrelated* individuals, who by reason of aging, illness, blindness, disease or physical or mental infirmity desire such service, and for which a charge is made.

Division of Statistical Services provides tabulating and statistical service to all of the sections and divisions of the State Board of Health. Original reports and documents checked and coded in the various divisions are routed to the statistical service division for machine processing, statistical tabulation and analysis. These tables and analyses are referred to the divisions concerned for final interpretation and are then used in program planning on state and local levels.

Division of Cosmetology enforces the state law governing cosmetology; examines and licenses all cosmetologists; registers apprentices in beauty salons and students in schools of cosmetology; licenses beauty and electrolysis salons and schools of cosmetology; inspects such establishments for proper sanitary practices.

Division of Barbering enforces state laws governing barbering and examines and licenses all persons engaged in barbering.

Division of Funeral Directing and Embalming enforces state laws governing funeral directors, embalmers, apprentices, and funeral establishments; registers apprentices and supervises the training program; examines and licenses all funeral directors and embalmers; licenses funeral establishments.

Section on Preventable Diseases

With the progress of medical science, many deadly diseases have been reclassified as preventable. This section is engaged in the vital task of keeping public health practices up to date. The basis for this activity is the systematic collection and analysis of morbidity and mortality data, aimed at directing not only administrative practices toward a reduction in the causes of sickness and death but also a retardation or halt in the progress of disease which is detected as early as possible.

Bureau of Communicable Diseases administers, promotes, and encourages local projects for the prevention of communicable diseases through the agency of the local health officers.

Division of Tuberculosis Control plans and assists in carrying out a comprehensive program aimed at the eradication of tuberculosis. To achieve this, it operates mobile x-ray units for the systematic mass survey of entire counties, and performs specific duties relative to the finding, treating, and rehabilitating of tuberculous persons. A central register of tuberculosis cases to aid local health agencies in the follow-up of all reported and suspected cases of tuberculosis is maintained.

This division has under its general supervision the activities of the Wisconsin State Sanatorium and Lake Tomahawk State Camp. Wisconsin State Sanatorium is a 241 bed institution which is operated primarily for the treatment of patients with incipient tuberculosis. Lake Tomahawk State Camp provides for the rehabilitation of male tuberculous patients.

Division of Venereal Disease Control accumulates information on the incidence of venereal diseases; seeks to find and bring under treatment all persons who have venereal disease in a communicable stage; provides follow-up of contacts for private physicians.

Division of Cancer Control encourages early diagnosis, adequate treatment, and follow-up of cancer patients; prepares statistical studies of case reports as a part of this program; cooperates with state and local medical and dental societies, state universities, the Wisconsin Division of the American Cancer Society, and other interested agencies and persons in conducting postgraduate, medical and lay education programs.

Division of Heart Disease Control is developing a program of professional and lay education, community service, and research to reduce morbidity and mortality from heart diseases, the leading cause of death.

Section on Environmental Sanitation

This section exercises general supervision and guidance over public health engineering activities in the state.

Bureau of Sanitary Engineering has specific functions described under the following headings:

PUBLIC WATER WORKS.—Maintains general supervision over the installation and operation of public water supplies, including the approval of plans and specifications for contruction; interstate carrier water supply certification in cooperation with the United States Public Health Service; promotes new systems.

PUBLIC SEWAGE WORKS.—Supervises the installation and operation of public sewage systems, including the approval of plans and specifications for construction; and promotes new systems.

MILK SANITATION.—Promotes adoption of uniform ordinances and codes and enforcement thereof, cooperates with the Department of Agriculture in supervising and certifying milk products for interstate shipment, and recommends certification of milk used on common carriers.

GENERAL SANITATION.—Supervises sanitary control over swimming pools and beaches, camps (recreational, industrial, trailer), garbage and refuse disposal, atmospheric pollution control, and other miscellaneous sanitation activities; certifies industrial camps.

Division of Plumbing licenses plumbers; enforces the state plumbing code; promotes adequate plumbing and sanitation in rural and urban areas, including the approval of plans for comfort stations and lake and stream plots.

Division of Well Drilling registers well drillers; administers the pure drinking water law and the state well construction code, issues permits on high capacity wells and supervises ground water developments.

Division of Rendering and Slaughtering inspects and licenses; approves sites and plans for new construction; promotes improved operation of plants.

Division of Water Pollution Control conducts pollution surveys; studies trade wastes and other pollution abatement measures, conducts routine and special stream surveys, conducts cooperative studies with industries, supervises aquatic nuisance control procedures, and renders other services for the State Committee on Water Pollution.

Section on Maternal and Child Health

Bureau of Maternal and Child Health directs its activities to programs and services that will reduce maternal and infant deaths and prevent physical and emotional illness and handicapping defects. To determine needs it studies and interprets statistical information from birth and death certificates and tries to keep professional and lay persons throughout Wisconsin informed on special problems. Local communities are aided in plans pertaining to health of expectant mothers and children; in-service training of staff and professional groups and community education; preparation and distribution of educational material, including prenatal letter service for expectant mothers; demonstration of community services; financial aid to a few of the poorer counties to help them maintain minimum health programs. Specific fields of activity follow.

OBSTETRIC AND PEDIATRIC EDUCATION is carried on through joint projects with the State Medical Society, using specialists from within and outside of the state for lectures or courses.

NURSING CONSULTANTS work through the district offices and directly with hospitals and public health agencies to help communities establish more adequate programs for mothers and children. They assist in interpreting community needs; in carrying on staff education projects; in demonstrating technical phases of nursing care; and in organizing parent education projects. Effort is made to coordinate the work of the public health and hospital nurses and to encourage referral of patients by the medical profession so that better patient-centered care results. Advice and demonstration are available to hospitals and health and social agencies. Incubators are placed in strategic hospitals for centering interest on the problem of the increasing number of premature deliveries and on the care of premature babies.

SCHOOL HEALTH. Consultant service is provided school administrators, supervisors, classroom teachers, teacher training institutions, and public health personnel by the school health consultant. The Wisconsin Cooperative School Health Plan is encouraged in all school systems in the state. The Medical Society is represented on the State School Health Council and also has a School Health Committee which offers advice on new plans and projects for improving physical and mental health.

Emphasis is placed on routine health supervision of preschool and school children by the family physician. Health series Bulletin No. 8, "School Health Examinations," was revised in 1951. It outlines for physicians and school personnel recommended procedures and prescribed forms.

Increased emphasis is placed on the physical fitness and health examinations of school personnel. Sec. 40.16 (14) Wisconsin Statutes, which enables school boards to require periodic health examinations, including chest x-rays of all persons working with school children, has resulted in extension of this important program. If not available from school superintendents, physicians may obtain from the State Board of Health sample copies of the recommended forms for school personnel examinations and the recommended physical examination forms for preschool and school children.

Division of Mental Health organizes educational and clinical programs in preventive aspects of mental health; demonstrates and supervises local community guidance centers; cooperates in training center for specialists in this area; participates in postgraduate medical education in preventive psychiatry and in-service training programs for public health workers, teachers, social workers; carries out programs of lay education through all media; acts in advisory capacity on mental health

matters to organizations and agencies; conducts studies on mental health programs; promotes and encourages local projects in community mental health education; provides physicians with bulletins, films on child problems; is affiliated with the University of Wisconsin to provide facilities for teaching psychologic aspects of child health care.

Local Preventive Mental Health Services

Brown County Child Guidance Center, 523 Howe Street, Green Bay: Elizabeth D. Kane, M. D., Director

Dane County Child Guidance Center, 433 State Street, Madison: Milford E. Barnes, M. D., Director

Dodge County Child Guidance Center, Court House, Juneau: Manuel Schreiber, M. D., Director

Douglas County Child Guidance Center, City Hall, Superior: Lawrence R. Gowan, M. D., Director

Fond du Lac County Child Guidance Center, Court House, Fond du Lac: C. J. Buscaglia, M. D., Director

Jefferson County Child Guidance Center, Court House, Jefferson: Hertha Tarrasch, M. D., Director

Kenosha County Mental Hygiene Clinic, 625 52nd Street, Kenosha: Harold T. Schroeder, M. D., Director

La Crosse County Child Guidance Center, 419 Newburg Bldg., La Crosse: C. F. Midelfort, M. D., Director

Manitowoc County Child Guidance Center, 1010 South 7th St., Manitowoc: Keith Keane, M. D., Director

Milwaukee County Guidance Clinic, Public Safety Building, Milwaukee: Sara Geiger, M. D., Director

Racine County Guidance Clinic, City Hall, Racine: Harold T. Schroeder, M. D., Director

Rock County Child Guidance Center, 26 South Bluff Street, Janesville: Hertha Tarrasch, M. D., Director

Sheboygan County Guidance Clinic, 211 Security National Bank Building, Sheboygan: Keith Keane, M. D., Director

Walworth County Child Guidance Center, Court House, Elkhorn: George Weber, M. D., Director

Waukesha County Child Guidance Center, Court House, Waukesha: Harold T. Schroeder, M. D., Director

State of Wisconsin General Hospital, Madison: Department of Neuropsychiatry.

The Division of Nutrition is responsible for developing a program for nutrition improvement so that people at all age levels may have the foods needed to maintain good health. A staff of nutritionists, who also are qualified, experienced dietitians, provide a variety of services: They visit small hospitals and nursing homes to assist the administrator and medical staff in developing good dietary standards and in planning for special diet needs. They aid in planning adequate facilities for kitchen and food service units in new or remodeled buildings. The nutritionists work with professional personnel in local health, welfare and educational agencies. They assist directors of children's institutions and camps in planning for more adequate food. In schools, they work with administrators to improve the quality of school lunches and to utilize the lunch program as a means of developing better food habits. They provide teachers with basic nutrition facts and guide them in planning nutrition education activities. Through pamphlets, newspaper releases, radio talks and community group discussions, the public is further provided with up-to-date nutrition information.

Section on Local Health Administration

This section is concerned with planning, organizing, and supervising the activities of the district offices, county, city-county, and multiple county health departments, and other bureaus and divisions in the section.

Division of Local Health Administration plans for, and assists in, the development of full-time city-county, county, and multiple county health departments throughout the state. It advises and assists local health officials in the 1,800 health districts through the nine district health offices. Help is given to local health departments in evaluating and directing their programs; making surveys and studies of local needs; securing financial aid; preparing budgets for local health departments; and planning and promoting a continuous program of professional education for public health personnel.

Maternity Hospitals inspects and licenses all establishments which care for maternity patients.

Nine District Health Offices. The state has been divided into nine districts by the State Board of Health, with a full-time medical officer in charge of public health activities in each district. An advisory public health nurse, sanitary engineer, and secretary make up the staff in each office. The personnel of these offices is available upon request for consultation on any questions pertaining to public health, control of communicable disease, public health nursing, or sanitation. A few of the districts have additional public health personnel, such as a nutritionist, dental hygienist, or health educator. Many of the districts have been assigned a hotel and restaurant inspector and a stream pollution engineer.

Bureau of Public Health Nursing gives consultant services to public health nurses and to public and voluntary health organizations regarding public health nursing policies and administration. It studies and analyzes reports of local public health nurses and prepares manuals, guides, records, and report forms to aid the local nursing services in guidance of local programs. A register of public health nurses is maintained, and credentials of qualified applicants are supplied to any employing body. It plans, encourages, and participates in continuous staff education programs for state, district, and local public health nursing staffs. It assigns

and supervises rural field experiences for public health nursing students.

Division of Industrial Hygiene makes studies to determine whether workers in all types of industries are exposed to poisonous dusts, fumes, vapors, or gases. If harmful exposures are found, recommendations for control are made to the management. The division provides nursing consultation and assistance in planning a part-time or full-time industrial nursing service and promotes medical programs that include physical examinations (preemployment and periodic re-examinations). Annual clinics for practicing physicians are organized on industrial health and safety problems. Research is conducted to develop new equipment and methods to evaluate the potential health hazards associated with the use of new industrial chemicals. This division works closely with the State Industrial Commission and other state departments to carry out an effective program.

Division of Hotels and Restaurants inspects and recommends proper sanitary conditions in hotels, restaurants, and other licensed places that serve food to assure the public of good wholesome food properly prepared and served, as well as a safe and sanitary environment. Hotels, restaurants, tourist rooms, tourist cottages, tourist cabins, roadside stands, taverns, drug stores or any other permanent place that serves food or furnishes lodging to the general public are licensed by this division. Also licensed are all eating places at fairs, carnivals, or similar gatherings to assure the public that a standard of sanitation and safety is maintained.

This division works with the Plumbing Division, Industrial Commission, local health departments, and other agencies to see that all lodging places or places that feed the general public are properly licensed and inspected for safety and sanitation from year to year. This inspectional work is supplemented by food handling schools conducted throughout the state to cover all phases of proper food handling practices.

COMMUNICABLE DISEASE RULES

CD 1.00 Communicable Diseases

The following are declared to be communicable diseases and the control measures for each specific disease shall be as herein provided. All reasonably suspected cases of communicable diseases shall be regarded as actual cases until proved otherwise and all rules and regulations applicable to actual cases shall be applied to them.

CD 1.01 Actinomycosis

A. Patient: (1) Placard—None. (2) Restrictions: Isolation: None, provided the patient is under medical supervision. (3) Reporting required.

B. Contacts: No restrictions.

C. Environment: (1) Concurrent disinfection of discharges from lesions and articles soiled therewith. (2) Terminal disinfection by thorough cleaning.

COMMUNICABLE DISEASES

Summary of Rules

Disease	Reportable	Isolation Patient	Restriction Contact	Placard
Actinomycosis	Yes	None if under medical care	None	None
Amebic dysentery	Yes	Food handling restricted	Food handling restricted	None
Anthrax	Yes	Until lesions healed	None	None
Bacillary dysentery	Yes	Food handling restricted	Food handling restricted	None
Brucellosis	Yes	None	None	None
Chickenpox	Yes	7 days from onset	None	None
Cholera	Yes	14 days or negative stools	5 days or negative stools	Yes
Diarrhea of the newborn	Yes	Special; see rule	See rule	None
Diphtheria	Yes	10 days and negative cultures	5 days and negative cultures	Yes
Encephalitis	Yes	7 days from onset	None	None
German measles	Yes	7 days from onset	None	None
Hemorrhagic jaundice	Yes	None	None	None
Hepatitis, infectious	Yes	7 days from onset	None	None
Histoplasmosis	Yes	None	None	None
Leprosy	Yes	Yes; see rule	None	None
Malaria	Yes	Until blood negative for parasites	None	None
Measles	Yes	7 days from start of rash	Susceptibles: 7 days beginning 2nd week exposure	None
Meningitis, meningococcal	Yes	14 days; see rule	None	None
Mumps	Yes	Minimum 7 days	None	None
Ophthalmia neonatorum	Limited	None if under medical care	None	None
Plague	Yes	Minimum 14 days	In pneumonic form, 7 days last exposure	Yes
Poliomyelitis	Yes	14 days from onset	Intimate contacts only; see rule	Yes
Psittacosis	Yes	During acute stage disease	None	None
Rabies	Yes	None if under medical care	None	None
Rheumatic fever	Yes	None	None	None
Smallpox	Yes	Until disappearance of crusts and scabs	18 days or successful vaccination within 3 days of exposure	Yes
Scarlet fever, septic sore throat	Yes	14 days or negative cultures	Limited; see rule	Yes
Erysipelas, puerperal infection	No	During acute stage disease	None	None
Tetanus	Yes	None	None	None
Tinea capitis	Yes	Limited; see rule	None	None
Trachoma	Yes	None if under medical care	None	None
Trichinosis	Yes	None	None	None
Tuberculosis	By name	Special; see rule	None	None
Tularemia	Yes	None	None	None
Typhoid fever	Yes	7 days after symptoms and negative cultures	Food handling restricted	Yes
Typhus	Yes	During febrile period	Delousing	None
Venereal diseases	Special	None if under medical care	Examination	None
Whooping cough	Yes	28 days from onset	Limited; see rule	None
Yellow fever	Yes	7 days	None	None

CD 1.02 Amebic Dysentery

A. Patient: (1) Placard: None. (2) Restrictions: Isolation—none. No person having amebic dysentery, or who is a carrier of amebic dysentery, shall handle, prepare, or serve food for public consumption until completion of treatment and three negative stool tests, taken not less than one day apart, are obtained. (3) Reporting: All cases and carriers of amebic dysentery shall be reported to the local health officer. The occupation of such persons shall be forwarded in the report.

B. Contacts: Restrictions: Quarantine—none. Contacts within the home are prohibited from handling or preparing food for public consumption un-

til 2 negative stool tests, on consecutive days, are obtained.

C. Environment: (1) Where the premises occupied by the patient or carrier are unsewered, the health officer shall cause all vaults and cesspools to be sufficiently disinfected and kept fly-proof and vermin-proof by screening or other effective arrangements. (2) Concurrent Disinfection: Sanitary disposal of the bowel discharges is required.

CD 1.03 Anthrax

A. Patient: (1) Placard—None. (2) Restrictions —Isolation until the lesions have healed. (3) Reporting required.

B. Contacts: No restrictions.

C. Environment: (1) Concurrent disinfection of the discharges from lesions and articles soiled therewith. (2) Terminal disinfection: Thorough cleaning.

CD 1.04 Bacillary Dysentery

A. Patient: (1) Placard—none. (2) Restrictions: Isolation—none. No person having bacillary dysentery, or who is a carrier of bacillary dysentery shall handle, prepare or serve food for public consumption which is not subsequently to be cooked until completion of treatment and 2 negative stool tests taken not less than one day apart. (3) Reporting: All cases and carriers of bacillary dysentery shall be reported to the local health officer. The occupation of such persons shall be forwarded in the report.

B. Contacts: Restrictions: Quarantine none. Contacts within the home are prohibited from handling or preparing food for public consumption until 2 negative stools are obtained.

C. Environment: (1) Where the premises occupied by the patient or carrier are unsewered, the health officer shall cause all vaults and cesspools to be sufficiently disinfected and kept fly-proof and vermin-proof by screening or other effective arrangements. (2) Concurrent disinfection: Sanitary disposal of the bowel discharges is required.

CD 1.05 Brucellosis

A. Patient: (1) Placard—None. (2) Restrictions —Isolation: None. (3) Reporting required.

B. Contacts: No restrictions.

C. Environment: (1) Concurrent disinfection: None. (2) Terminal disinfection: None.

CD 1.06 Chickenpox

A. Patient: (1) Placard none. (2) Restrictions: The patient is to be isolated for seven days at home from date of onset. (3) Reporting: All cases are to be reported to the local health officer. The diagnoses of all cases of chickenpox occurring in persons over 15 years of age are to be verified by a physician. Where a physician is not employed by the family, the local board of health is required to furnish a physician for the verification of such diagnosis.

B. Contacts: Restrictions: Quarantine none. Well children in the family may attend school but are to be observed by the teacher and excluded if they show any evidence of illness.

C. Environment: There is to be concurrent disinfection of all articles soiled by discharges from the nose and throat as well as from the lesions.

CD 1.07 Cholera

A. Patient: (1) Placard required. (2) Restrictions: The patient is to be isolated in a hospital or a well screened room for fourteen days or until the stool is found to be free from cholera vibrio on three consecutive days. (3) Reporting: All cases are to be reported to the local health officer within twenty-four hours.

B. Contacts: Restrictions: All contacts are to be quarantined for a period of five days from the date of last exposure and until 2 negative, consecutive cultures are obtained.

C. Environment: (1) Concurrent disinfection. There is to be prompt and thorough disinfection of the stools and vomitus. Articles used by and in connection with the patient are to be disinfected. Food left by the patient is to be burned. (2) Terminal disinfection: The room in which a patient was isolated is to be thoroughly cleaned.

CD 1.08 Diarrhea of the Newborn

A. Patient: (1) Placard none. (2) Restrictions: Immediate removal of affected baby from nursery to isolation ward. Closure of contaminated nursery to new admissions and suspension of maternity service. (3) Reporting: The occurrence of any case of diarrhea of the newborn is to be immediately reported to the local health officer in those communities which employ a full-time health officer. In those communities where a full-time health officer is not employed, the occurrence of diarrhea of the newborn is to be reported directly to the Wisconsin State Board of Health.

B. Contacts: Restrictions: All exposed babies in the nursery are to be cared for by separate medical and nursing personnel.

C. Environment: (1) All articles within the nursery are to be disinfected as thoroughly as practical. (2) Terminal disinfection—thorough cleansing of the premises.

CD 1.09 Diphtheria

A. Patient: (1) Placarding required. (2) Restrictions: The patient is to be isolated for at least ten days and until 2 consecutive, negative nose and throat cultures, taken not less than twenty-four hours apart, are obtained. (3) Reporting: All cases and carriers shall be reported to the local health officer.

B. Contacts: Restrictions: All intimate contacts are to be quarantined for at least five days and until 2 consecutive, negative nose and throat cultures are obtained. Children in the family with the patient may not return to school until all persons within the affected household have been shown to no longer carry the etiologic agent.

C. Environment: (1) All carriers of diphtheria bacilli are to be handled as cases unless laboratory examination demonstrates that the organisms are not virulent. (2) All articles which have been in contact with the patient and all articles soiled by discharges of the patient are to be concurrently disinfected.

CD 1.10 Encephalitis

A. Patient: (1) Placard none. (2) Restrictions: The patient is to be isolated in a well-screened room for an interval of seven days from the onset of the disease. (3) Reporting: All cases are to be reported to the local health officer within twenty-four hours.

B. Contacts: Restrictions: Quarantine none.

C. Environment: Concurrent disinfection: None except for the purpose of destroying mosquitoes in the house occupied by the patient and in the nearest neighboring dwellings.

CD 1.11 German Measles

A. Patient: (1) Placard none. (2) Restrictions: Isolation at home for seven days from onset. (3) Reporting: All cases are to be reported to the local health officer.

B. Contacts: (1) Restrictions: Quarantine none. (2) Other children in the family may attend school but are to be observed by the teacher and excluded if they show evidence of illness.

CD 1.12 Hemorrhagic Jaundice

A. Patient: (1) Placard—None. (2) Restrictions —Isolation: None. (3) Reporting required.

B. Contacts: No restrictions.

C. Environment: (1) Concurrent disinfection: Urine and other discharges of patient. (2) Terminal disinfection: None.

CD 1.13 Hepatitis, Infectious

A. Patient: (1) Placard—None. (2) Restrictions: Isolation during the first week of illness. (3) Reporting required.

B. Contacts: No restrictions.

C. Environment: (1) Concurrent disinfection: Discharges of nose, throat, and bowels of the patient. (2) Terminal disinfection: None.

CD 1.14 Histoplasmosis

A. Patient: (1) Placard—None. (2) Restrictions —None. (3) Reporting required.

B. Contacts: No restrictions.

C. Environment: No requirements.

CD 1.15 Leprosy

A. Patient: (1) Placard none. (2) Restrictions: The patient is to be isolated at home until transferred to a national leprosarium. (3) Reporting required.

B. Contacts: No restrictions.

C. Environment: (1) Concurrent disinfection of all discharges and articles soiled with discharges from the patient. (2) Terminal disinfection: Cleansing of premises after removal of patient.

CD 1.16 Malaria

A. Patient: (1) Placard none. (2) Restrictions: Isolation in a well-screened room until blood is negative for parasites. (3) Reporting required.

B. Contacts: Restrictions: Quarantine none.

C. Environment: Concurrent disinfection: None except for the purpose of destroying mosquitoes in the house occupied by the patient and in the nearest neighboring dwellings.

CD 1.17 Measles

A. Patient: (1) Placard none. (2) Restrictions: Isolation at home for seven days upon appearance of rash. (3) Reporting required.

B. Contacts: Restrictions: Susceptible contacts in the home are to be restricted to the premises beginning the second week after exposure for a period of seven days.

C. Environment: Concurrent disinfection: All articles soiled with secretions of the nose and throat are to be concurrently disinfected.

CD 1.18 Meningitis, Meningococcic

A. Patient: (1) Placard none. (2) Restrictions: Isolation until forty-eight hours after the institution of treatment with a sulfonamide or penicillin. In the absence of such treatment the patient is to be isolated for two weeks. (3) Reporting: The occurrence of meningococcic meningitis is to be reported to the local health officer within twenty-four hours.

B. Contacts: Restrictions: Quarantine none.

C. Environment: There is to be concurrent disinfection of discharges from the nose and throat or articles soiled with these discharges.

CD 1.19 Mumps

A. Patient: (1) Placard none. (2) Restrictions: Isolation of patient for at least one week or until disappearance of swelling. (3) Reporting required.

B. Contacts: Restrictions: Quarantine none. Other children in the family may attend school but are to be observed by the teacher and excluded if they show any evidence of illness.

CD 1.20 Ophthalmia Neonatorum

A. Patient: (1) Placard—None. (2) Restrictions —None provided the patient is under adequate medical supervision. (3) Reporting—None except as provided in Sec. 146.01 (2) which requires reporting to the local health officer in cases not attended by a physician or midwife.

B. Contacts: No restrictions.

C. Environment: (1) Concurrent disinfection of conjunctival discharges and soiled articles. (2) Terminal disinfection—Thorough cleaning.

D. Prevention: The attending physician or midwife is required to place 2 drops of a 1 per cent solu-

tion of silver nitrate in each eye of a newborn child immediately after delivery. Failure to observe this requirement is punishable by a fine of not more than one hundred dollars. (Section 146.01)

CD 1.21 Plague

A. Patient: (1) Placard required. (2) Restrictions: Isolation of patient in a hospital or well-screened room which is free from vermin for a period of at least two weeks. (3) Reporting required.

B. Contacts: Restrictions: Quarantine of persons exposed to the pneumonic form of the disease for a period of one week from the date of last exposure.

C. Environment: (1) Concurrent disinfection of sputum and soiled articles. (2) Extermination of rats and vermin from the premises.

CD 1.22 Poliomyelitis

A. Patient: (1) Placard required. (2) Restrictions: The patient is to be isolated for a period of at least two weeks from the onset of the symptoms. (3) Reporting: All cases are to be reported to the local health officer as soon as the diagnosis is established. At the time of release from isolation a second report is to be made for the purpose of verifying the original diagnosis and stating whether the patient was afflicted with a paralytic or non-paralytic form of the disease.

B. Contacts: Restrictions: Intimate contacts under 18 years of age are to be quarantined for two weeks. Intimate contacts who are adults: Teachers and others who come in contact with children and food handlers must cease their occupation for an interval of two weeks.

C. Environment: Concurrent disinfection: All discharges from the nose and throat and bowel are to be concurrently disinfected.

CD 1.23 Psittacosis

A. Patient: (1) Placard—None. (2) Restrictions: Isolation during the febrile and acute clinical stage of the disease. (3) Reporting required.

B. Contacts: No restrictions.

C. Environment: (1) Concurrent disinfection of all discharges. (2) Terminal disinfection—Destruction of infected birds.

CD 1.24 Rabies

A. Patient: (1) Placard—None. (2) Restrictions: Isolation: None if the patient is under medical supervision and the immediate attendants are warned of possibility of inoculation by human virus. (3) Reporting required.

B. Contacts: No restrictions.

C. Environment: (1) Concurrent disinfection of saliva of patient and articles soiled therewith. (2) Terminal disinfection: None.

CD 1.25 Rheumatic Fever (Active)

A. Patient. (1) Placard—None. (2) Restrictions —None. (3) Reporting required.

B. Contacts: No restrictions.

C. Environment: No requirements.

CD 1.26 Smallpox

A. Patient: (1) Placard required. (2) Restrictions: Isolate until the disappearance of all scabs and crusts. (3) Reporting required.

B. Contacts: Restrictions: Quarantine for eighteen days from date of last exposure unless a successful vaccination has been obtained within three days of exposure.

C. Environment: (1) Concurrent disinfection: No article is to leave the immediate surroundings of the patient without boiling or equally effective disinfection. (2) Terminal disinfection: Thorough cleaning of the premises.

CD 1.27 Streptococcic Diseases, Respiratory Form Scarlet Fever and Septic Sore Throat

A. Patient: (1) Placard required. (2) Restrictions: The patient is to be isolated for fourteen days and until suppurative discharges cease. Where laboratory facilities are available, isolation may be terminated after obtaining two consecutive, negative nose and throat cultures, which are not less than twenty-four hours apart. (3) Reporting required.

B. Contacts: Restrictions: Intimately exposed children shall be quarantined to the premises if the contact is not broken. The period of quarantine shall be the same as the period of isolation for the patient. If the contact is broken, the period of quarantine shall be for five days or until two consecutive, negative nose and throat cultures, not less than 24 hours apart, are obtained. Adult contacts are not to be restricted except in the case of food handlers and teachers. Adults engaged in the preparation, handling and serving of food shall not be permitted to engage in the handling of food for an interval equal to the isolation period of the patient if contact is not broken. If contact is broken, food handlers may not engage in the preparation, handling and serving of food for an interval of five days. Teachers intimately exposed in the place of residence shall not attend school or associate with groups of children for five days after exposure.

C. Environment: (1) Concurrent disinfection: All articles which have been soiled by purulent discharges and all articles which have been in contact with the patient are to be concurrently disinfected. (2) Terminal disinfection: A thorough cleaning of contaminated objects, scrubbing of floors and sunning of blankets to prevent dissemination of infected particles.

CD 1.28 Streptococcic Diseases Other Than Respiratory Erysipelas and Puerperal Infection

A. Patient: (1) Placard none. (2) Restrictions: The patient is to be isolated for the duration of the acute stage of the disease. (3) Reporting none.

B. Contacts: Restrictions none.

C. Environment: (1) Concurrent disinfection: Careful disposal of dressings and discharges from the patient. (2) Terminal Disinfection: General thorough cleaning of blankets, linen, and room.

CD 1.29 Tetanus

A. Patient: (1) Placard—None. (2) Restrictions —None. (3) Reporting required.

B. Contacts: No restrictions.

C. Environment: (1) Concurrent disinfection— None. (2) Terminal disinfection—None.

CD 1.30 Tinea Capitis (Ringworm scalp)

A. Patient: (1) Placard—None. (2) Restrictions: Exclusion from school until recovery unless (a) under continuous treatment of physician licensed to practice medicine, and wears a suitable head covering until cured, or (b) separate class room provided for infected patients. (3) Reporting required.

B. Contacts: Upon discovery of a clinical case of ringworm of the scalp, all contacts under 15 and all school children in the classroom should be inspected and examined with suitable filtered ultraviolet light. Resurveys should be continued until one month after last case is detected.

C. Environment: (1) Concurrent disinfection — Stocking caps and inexpensive head coverings should be frequently laundered and destroyed by burning after use. (2) Terminal disinfection—None.

CD 1.31 Trachoma

A. Patient: (1) Placard—None. (2) Restrictions —Isolation: None, if under medical supervision. (3) Reporting required.

B. Contacts: No restrictions.

C. Environment: (1) Concurrent disinfection of eye discharges and articles soiled therewith. (2) Terminal disinfection—None.

CD 1.32 Trichinosis

A. Patient: (1) Placard—None. (2) Restrictions —None. (3) Reporting required.

B. Contacts—No restrictions.

C. Environment: (1) Concurrent disinfection— None. (2) Terminal disinfection—None.

CD 1.33 Tuberculosis

A. Patient: (1) Placard—None.

(2) Restrictions: *(a)* All individuals afflicted with tuberculosis of the lungs in the communicable form or reasonably suspected of being so afflicted shall exercise all reasonable precautions so as to prevent the infection of others with whom they may come in contact. The principal reasonable precautions are declared to be:

1. Depositing sputum in a special receptacle and disposing of material by burning or thorough disinfecting.
2. Preventing spraying when coughing by coughing into a container or paper napkin held to the mouth or nose.
3. Using individual eating utensils sterilized by boiling after each use.
4. Using separate towels.
5. Sleeping alone.
6. Avoiding coming in contact with other individuals on all possible occasions.
7. Refraining from handling liquids or foodstuffs to be consumed by others or the utensils connected with such handling.

(b) Any individual afflicted with tuberculosis of the lungs in the communicable form, diagnosed as such by a licensed physician or as shown by x-ray or the presence of tubercle bacilli in the sputum, in order to protect others from becoming infected, may be isolated on his premises by the local board of health or the health officer on the direction of the State Board of Health or state health officer, or by the full-time medical health officer of any city or county with a population of 250,000 or more within his jurisdiction.

(c) A placard shall be posted in a conspicuous position on the premises, with the words "communicable disease" in letters not less than two inches high.

(d) The local board of health or health officer may employ as many persons as are necessary to execute its orders and properly guard any patient in isolation if isolation is violated or intent to violate isolation is manifested. Such persons shall be sworn in as guards, shall have police powers, and may use all necessary means to enforce the state laws for the prevention and control of communicable diseases, or for the enforcement of these rules and regulations.

(e) The expense of maintaining isolation, including examinations and tests to determine the presence or communicability of the disease, and the enforcement of isolation on the premises, shall be paid by the city, incorporated village or town upon order of the local board of health. The expenses for necessary nurses, medical attention, food and other articles needed for the comfort of the afflicted person shall be charged against him or whoever is liable for his support. Indigent patients shall be cared for at public expense.

(f) Any individual who has been isolated on the premises under provision of these rules shall be released from such isolation by the local board of health or health officer on direction of the State Board of Health or state health officer or by the full-time medical health officer of any city or county with a population of 250,000 or more within his jurisdiction when in the opinion of said health officer the isolation is no longer necessary to protect others from becoming infected.

(g) No person with tuberculosis of the lung or other part of the respiratory tract in the communicable form, or reasonably believed to be suffering from such disease, shall be permitted to attend or frequent any school except open-air schools especially equipped for the purpose until the health officer of the municipality where the school is situated furnishes a written certificate stating that the individual is free from a communicable form of tuberculosis. Such certificate shall only be issued after thorough examination by a licensed physician in a manner satisfactory to the State Board of Health.

(h) If an individual afflicted with tuberculosis in a communicable form shall leave the sanatorium against the advice of the medical superintendent or

medical supervisor, such an individual shall be reported to the local board of health and may be isolated upon his premises as provided in Section (b) if in the opinion of the State Board of Health or the state health officer or of the full-time medical health officer of cities or counties with a population of 250,000 or more, agree that isolation is necessary in order to protect others from becoming infected.

(i) The local health officer or an individual delegated by him shall visit all individuals isolated for tuberculosis at least once every 15 days to ascertain that the isolation is being maintained and to ascertain whether to make recommendations for release from isolation or for admission to a tuberculosis sanatorium.

(j) Any individual isolated for tuberculosis may obtain release from such isolation by being admitted to a tuberculosis sanatorium.

(k) Individuals afflicted with tuberculosis in any form and diagnosed as such by a competent physician shall exercise every care and precaution for the protection of others.

(3) Reporting—By name to local health officer.

B. Contacts: No restrictions.

C. Environment: Disinfection: All handkerchiefs, towels, cloths, eating utensils and other contaminated material used by a person with tuberculosis shall receive appropriate disinfection before coming in contact with others. Upon the death or removal of a person with tuberculosis the health officer shall require disinfection of the premises occupied by the patient by a thorough washing of the woodwork by soap and water or a disinfectant, boiling of the dishes and contaminated fabrics, and a thorough sunning of material which can not be subjected to other disinfection.

It is the intent of these rules and regulations to give reasonable protection to the public from exposure to an individual afflicted with pulmonary tuberculosis in the communicable form.

CD 1.34 Tularemia

A. Patient: (1) Placard—None. (2) Restrictions —Isolation: None. (3) Reporting required.

B. Contacts: No restrictions.

C. Environment: (1) Concurrent disinfection of discharges from the ulcer, lymph glands, or conjunctival sac. (2) Terminal disinfection—None.

CD 1.35 Typhoid Fever

A. Patient: (1) Placard required. (2) Restrictions: Isolation for at least one week beyond the time that all symptoms subside and until two negative, consecutive specimens of feces and urine are obtained at least five days apart. (3) Reporting required.

B. Contacts. (1) Quarantine none. (2) Family contacts are not to be permitted to handle food during the period of contact or before two negative, consecutive stool and urine cultures are obtained.

C. Environment: (1) Concurrent disinfection of all bowel and urinary discharges and articles soiled with them. (2) Terminal disinfection through a thorough cleaning of the premises. (3) Suppression of flies.

D. Typhoid (Paratyphoid) Carrier:

1. Definition: A person shall be considered a typhoid (paratyphoid) carrier, capable of transmitting the disease to susceptible persons if:

(a) During or following his convalescence from the disease his feces and urine have not been proved free from typhoid (or paratyphoid) bacilli by examination in an approved laboratory (temporary carrier).

(b) He has not suffered from typhoid (or paratyphoid) fever within one year, but typhoid (or paratyphoid) bacilli are found in his urine or feces when examined in an approved laboratory (chronic carrier).

(c) Epidemiologic evidence points to such person as the source of one or more cases of the disease and from whom for any reason specimens of urine or feces have not or can not be obtained for examination in an approved laboratory.

2. Rules:

(a) The urine and feces of a typhoid carrier shall be disposed of in such a manner as not to endanger any public or private water supply or be accessible to insects or rodents.

(b) If food products, which are to be consumed raw by others, are produced on premises occupied by a typhoid carrier, the water supply shall be proven free from contamination.

(c) No typhoid carrier shall engage in the handling or preparation of any food or drink to be consumed on the premises by others than members of his family with whom he resides or to be consumed off the premises prior to cooking. This restriction shall apply to visitors, roomers, lodgers, and employes.

(d) No typhoid carrier shall engage in the occupation of nurse, nurse-maid, domestic servant, cook, waiter, dishwasher, or public eating-house employee.

(e) No typhoid carrier shall engage in any occupation involving the handling of milk, cream, or milk products, or the utensils used in the production thereof. No typhoid carrier shall reside on premises where milk is produced for distribution off the premises unless the carrier, or if he be a minor, his parent or legal guardian, and the owner of the milk-producing cows agree in writing:

(1) That the carrier will not engage in milking or handling of milk, cream or dairy utensils, or enter the house or barn where milk is produced or handled.

(2) That no milk or cream is to subsequently be sold nor that any utensils used in the production of milk or cream shall be brought into the house occupied by the carrier.

(3) That all persons residing or employed on the premises who are susceptible to typhoid shall be vaccinated against typhoid fever at least every three years.

Where the provisions of such agreement are not followed, distribution and sale of milk from such premises are prohibited.

(f) No typhoid carrier shall reside in or be employed in a boarding house or camp.

(g) No carrier shall change his place of residence without notifying the local health officer of his intended residence, who shall immediately inform the State Board of Health of the facts.

(h) In any situation not covered by the above rules and in which a typhoid carrier endangers the public health, the carrier shall observe such recommendations as the State Board of Health may make for the particular case.

3. Release of typhoid carriers:

(a) Following isolation for typhoid fever a person adjudged a temporary carrier may be released from restrictions only after two successive specimens each of urine and feces, passed at an interval of not less than five days, shall have been examined in an approved laboratory and found free from typhoid (or paratyphoid) bacilli; except that if the person is to handle milk, dairy or food products the number of negative cultures shall be four, two of which shall have been examined in the State Laboratory of Hygiene.

(b) A person adjudged a chronic carrier and who has not suffered from typhoid (or paratyphoid) fever within one year may be released from restrictions only on approval of the state health officer, and after certain conditions have been met.

4. Conditions for release of chronic typhoid carriers:

(a) If the gall bladder has not been removed

(1) Three specimens of duodenal contents taken in a hospital at intervals of not less than 24 hours shall have been examined in an approved laboratory and found to contain no typhoid bacilli.

(2) Each of at least 18 successive specimens of feces taken at intervals of 30 days under conditions that do not permit of substitution, have been examined in the State Laboratory of Hygiene and found to contain no typhoid bacilli.

(b) If the gall bladder has been removed

(1) Subsequent to removal of gall bladder each of three specimens of duodenal contents, taken in a hospital at intervals of not less than 24 hours, shall have been examined in an approved laboratory and found to contain no typhoid bacilli.

(2) Each of at least six successive specimens of feces taken at intervals of 30 days under conditions that do not permit of substitution, has been examined in the State Laboratory of Hygiene and found to contain no typhoid bacilli.

CD 1.36 Typhus

A. Patient: (1) Placard—None. (2) Restrictions: Delousing, isolation in vermin-free room during febrile period. (3) Reporting required.

B. Contacts—Restrictions: None required if delousing carried out.

C. Environment: (1) Concurrent disinfection—Use of insecticide powders on clothing and bedding and special treatment of hair for nits. (2) Terminal disinfection—None.

CD 1.37 Venereal Diseases

A. The State Board of Health declares the following venereal diseases, namely, syphilis, gonorrhea and chancroid as contagious, infectious, communicable and dangerous to the public health.

B. All Infected Persons Subject to Control.—All persons having venereal disease shall be subject to such control as public safety requires.

C. Who is to Report Venereal Disease.—Any physician who attends, treats or examines a person with venereal disease in communicable form; and any superintendent or manager of a hospital, dispensary, charitable or penal institution having knowledge of any such case not known to be previously reported, shall report such case to the State Board of Health. Such report shall be by designated number, age, sex, conjugal condition and duration of disease. The physician shall inquire into the source of infection and shall report any person known to a reasonable certainty to be the source by name and address to the State Board of Health. Any person knowing of a case of venereal disease not under the care of a physician and believed to be a menace to the public health shall report the name and address directly to the State Board of Health.

D. Reporting of Cases Delinquent in Treatment.—Whenever any person suffering from syphilis, gonorrhea or chancroid in a communicable form shall fail to return to the physician treating such person in reasonable time, such person shall be reported by name and address to the State Board of Health as delinquent in treatment.

E. Examination of Certain Classes Suspected of Having Venereal Disease.—It shall be the duty of each superintendent, manager or physician of any state, county, municipal, charitable or correctional institution, the warden of the state prison, the sheriff and other keepers of any jail or other penal institution to cause an examination to be made of all inmates suspected of having a venereal disease and said examination shall be made by a method satisfactory to the State Board of Health. Vagrants, prostitutes, frequenters of houses of prostitution, and persons guilty of illicit cohabitation are hereby declared to be reasonably suspected to have venereal disease. Any such person found to be infected with any of the venereal diseases in a communicable stage shall be kept in such

quarters as not to expose others. Such persons and all legally committed persons with a venereal disease, which is communicable to others, at expiration of commitment shall hereby be considered under quarantine and shall so remain until satisfactory arrangements can be made for care and treatment by a licensed physician at place of subsequent residence or until other disposition of the case is made by the State Board of Health.

F. Isolation.—Whenever a case or suspected case of venereal disease is found on premises where the case cannot be properly controlled during the period of infectiousness, or whenever a case of venereal disease in the infectious stage refuses or neglects care or treatment by a physician licensed to prescribe drugs, or is unmanageable and other persons are endangered, a placard may be placed on the premises occupied by the patient. Such placard shall be applied in emergency and not in lieu of commitment to an institution under Chapter 143.07, Laws of Wisconsin. The placard sign shall have the words "Communicable Disease." Violation of the requirements imposed by the placard shall be deemed a violation of these regulations. The local health officer shall be required by the State Board of Health to impose such isolation and enforce its requirements.

G. Sexual Contacts—Examination of.—All persons reported to be sexual contacts by any person with venereal disease in a communicable form shall be regarded as suspected cases and may be required by an official of the State Board of Health to be examined by a physician in a manner satisfactory to the State Board of Health.

H. Indigents—Treatment Facilities.—Local health officers and local boards of health shall cooperate with the State Board of Health in establishing treatment facilities for indigent persons with venereal disease. Local health officers shall report to the State Board of Health all cases of venereal disease reported to them.

I. Forbidden Occupations.—Persons suspected to be or knowing themselves to be afflicted with a communicable venereal disease shall not engage in the care or nursing of children or of the sick, nor shall they engage in any occupation the nature of which is such that their infection may be communicated to others. In the interests of the public health a medical health officer or officer of the State Board of Health may confidentially inform any person so endangered.

J. Issuing Certificates of Freedom From Venereal Disease Forbidden.—No physician or health officer shall issue certificates of freedom from any venereal disease to any person except those certificates required by law for marriage licenses and those required by local ordinances to be issued to local health officers. No person shall carry or exhibit such certificates to other persons or show, for immoral purposes, venereal disease reports from any laboratory. Such procedure is declared by the State Board of Health to be inimical to public health and public welfare.

K. Minors.—The parents or guardians of minors acquiring venereal disease shall, when notified, be legally responsible for the compliance of such minors with the requirements of these regulations.

L. Communicability—Definition of.—All cases of venereal disease shall be regarded as communicable until the following requirements have been met:

1. Syphilis*

Until open sores, ulcers, rashes, syphilitic sore throat or other open syphilitic lesions are healed; and also until satisfactory care and treatment as hereinafter defined has been given to any of the following: Pregnant women with syphilis; females who have given birth to a syphilitic child; syphilitic persons at any stage of the disease who, reasonable evidence indicates, are promiscuous in sexual relations and are a menace to others; and persons with early syphilis not adequately treated.

Adequate treatment shall be considered to be the administration of not less than twenty doses of arsenicals and twenty doses of heavy metal or equally effective treatment by a physician licensed to prescribe drugs. This other effective treatment shall be such as considered adequate by the State Board of Health.

2. Gonorrhea

A. Male:

1. Freedom from discharge.

2. Clear urine, no shreds.

3. Urethral smears must be negative for gonococci on four successive examinations at intervals of not less than one week.

4. Prostatic smears negative to gonococci on two successive tests not less than one month after conclusion of specific treatment.

5. When penicillin is used for the treatment of gonorrhea, a blood test for syphilis shall be taken at monthly intervals for a three month period.

B. Female:

1. No unusual vaginal discharge.

2. Two successive negative examinations for gonococci of the secretions of the urethra, vagina and of the cervix with an interval of at least forty-eight hours, and repeated for four successive weeks.

3. When penicillin is used for the treatment of gonorrhea, a blood test for syphilis shall be taken at monthly intervals for a three month period.

The labia should be held apart and a swab applied so as to express any secretions from Skenes or Bartholin's glands, which is then taken up on the swab.

In preparing urethral slides the finger should be inserted in the vagina and expression made on the floor of the urethra from within outward, the cot-

* Note: Does not apply to Section 143.07, subsection 4.

ton-tipped probe being then introduced well into the meatus. In procuring a smear from the cervix a vaginal speculum should be introduced and the cervix well exposed. All secretions should be mopped away from the external os before taking the smear. After the cervix is well dried a probe tightly wound with cotton should be inserted in the cervical canal and rotated several times.

3. Chancroid

Until all lesions are healed.

CD 1.38 Whooping Cough

A. Patient: (1) Placard none. (2) Restrictions: Isolation for three weeks after onset of typical paroxysms, or a total of twenty-eight days from onset of the catarrhal stage. (3) Report required.

B. Contacts: Restrictions: Other children in the family may attend school but are to be observed by the teacher and excluded if they evidence any symptoms of illness. Those children exposed to whooping cough who develop coughs or colds must be kept in isolation in their home until a diagnosis is established.

C. Environment: (1) Concurrent disinfection of the discharges from the nose and throat and of articles soiled with such discharges. (2) Terminal disinfection. A thorough cleaning of the premises.

CD 1.39 Yellow Fever

A. Patient: (1) Placard none. (2) Restrictions: Isolation in a well-screened room for seven days. (3) Reporting required on all cases to the local health officer within twenty-four hours.

B. Contacts: Restrictions: Quarantine none.

C. Environment: Concurrent Disinfection: None except for the purpose of destroying mosquitoes in the house occupied by the patient and in the nearest neighboring dwellings.

CD 2.00 Reporting

All communicable diseases which are designated as reportable under these rules shall be reported by all physicians and other persons having knowledge of such diseases to the local health officer and by the local health officer to the State Board of Health unless otherwise specifically provided.

CD 3.00 Definitions

3.01. *Case.* A person whose body has been invaded by an infectious agent, with the result that symptoms have occurred.

3.02. *Carrier.* A person who harbors a specific infectious agent without demonstrating symptoms or signs of the disease.

3.03. *Contact.* A person who has been intimately in contact with an infected person, such as the daily contact of a patient with his parents, his brothers and sisters, other occupants of the home and the like.

3.04. *Isolation.* By isolation is meant the separation of cases or carriers from other persons in such places and under such conditions as will prevent the direct or indirect conveyance of the infectious agent to susceptible persons.

3.05. *Quarantine.* By quarantine is meant the limitation of freedom of movement or isolation of contacts who have been exposed to a communicable disease, for a period of time equal to the longest usual incubation period of the disease to which they have been exposed.

3.06. *Disinfection.* Disinfection denotes the destruction of infectious agents by chemical or physical means. In general, two types of disinfection are employed:

A. *Concurrent.* Disinfection carried on continuously during the illness of the patient, such as destruction by use of chemical or physical means of discharges of the patient and cleaning of any infectious material which has come into contact with the patient or may have been soiled by him.

B. *Terminal.* The elimination of the infectious agent from personal clothing, belongings, and the immediate physical environment of the patient.

CD 4.00 Enforcement

It shall be the duty of the health officer of every local board of health in this state to enforce the rules of the State Board of Health covering communicable diseases or a suspected case of communicable disease whenever a case is reported or becomes known to him within his jurisdiction.

CD 5.00 School Attendance (formerly Rule 17)

All teachers, school authorities, and health officers having jurisdiction shall not permit the attendance in any private, parochial or public school of any pupil afflicted with a severe cough, a severe cold, itch, scabies, lice or other vermin, ring worm, impetigo, epidemic jaundice, Vincent's angina (trench mouth), infectious conjunctivitis (pink eye), or any contagious skin disease, or who is filthy in body or clothing, or who has any communicable disease so designated by the State Board of Health unless specifically exempted in the rules. The teachers in all schools shall, without delay, send home any pupil who is obviously sick even if the ailment is unknown, and said teacher shall inform the parents or guardians of said pupil and also the local health officer as speedily as possible, and said health officer shall examine into the case and take such action as is reasonable and necessary for the benefit of the pupils and to prevent the spread of infection.

Parents, guardians or other persons having control of any child who is sick in any way, or who is afflicted with any disease covered by this rule, shall not permit said child to attend any public, private or parochial school or to be present in any public place.

CD 6.00 Sale of Milk and Dairy Products From Infected Home Restricted

The sale or use of milk or dairy products from a place where cholera (Asiatic), diphtheria, poliomyelitis, plague, scarlet fever, smallpox, or typhoid fever is found to exist is strictly forbidden unless the milk is handled, milk utensils washed and stock cared for and the product transported by persons entirely disassociated from the quarantined family.

CD 7.00 Release Cultures

Where release cultures are required in communicable diseases, such cultures shall be examined in a laboratory approved by the State Board of Health.

CD 8.00 Transporting Patients

When it is necessary to transport a person suffering with a dangerous communicable disease from one town, village or city to another, the consent of the health officer where the patient lives and also the health officer of the town, village or city to which the patient will be transported must first be obtained. Transportation must be made by private conveyance and proper precautions exercised to prevent needless exposure of all persons who may come in contact with the patient during transit.

CD 9.00 Exclusion From School, Assemblages, and Public Conveyances

No person suffering from any communicable disease so designated by the State Board of Health shall be admitted to any public, parochial or private school, college or Sunday school, or shall enter any theatre, assemblage, or railway car, street car, vessel or steamer, or other public conveyance, except as specifically provided in the communicable disease rules.

CD 10.00 Mail in Placarded Home

No mail or other materials shall be sent from a placarded home unless such mail or materials have been prepared and disinfected under the direction of the local health officer.

CD 11.00 Books Not to Be Taken Into Infected Homes

Schoolbooks or books from public or circulating libraries shall not be taken into any house placarded for communicable disease and if schoolbooks or library books have already been taken in such house they shall be destroyed by the owner or library authorities or thoroughly disinfected.

Disinfection of books—In cases where it is desirable to disinfect books which may have become infected with dangerous communicable disease the following requirements must be followed:

Library books which have been in a placarded home should be withheld from circulation for a period of fifteen days and so arranged each day that the sunlight can reach the maximum number of surfaces.

Books used by a tubercular person should either be destroyed or withheld from circulation for at least one month and during this time kept standing in the sunlight opened so that the rays of the sun can reach the maximum number of pages. Surfaces should be changed from day to day. Time and sunlight are recommended as the best means to accomplish the destruction of infectious material deposited upon books.

CD 12.00 Public Funerals Prohibited

12.01. Public or church funerals shall not be held for persons dead of smallpox. Every person who attends the funeral, including members of the family, shall, within 24 hours of attending the funeral or exposure, submit to vaccination for smallpox or produce evidence from a physician of successful vaccination within the past two years.

12.02. Whenever death is due to cholera (Asiatic), diphtheria, poliomyelitis, plague, or scarlet fever, the household and family contacts of the deceased shall not be permitted to attend public or church funerals for the deceased nor to have any association with the public until the specific restrictions governing contacts have been fulfilled.

12.03. The above rules shall apply to funerals of those dead from suspected cases as well as diagnosed cases of the diseases above specified, but shall not apply to those dying from late complications of such diseases after the communicable period is past, and after the family is released from quarantine.

12.04. During periods of epidemic, diseases of any nature found sufficiently malignant to justify private funerals and in the case of death from unusual forms of virulent disease, apparently communicable in nature, the local board of health with the consent of the State Board of Health may prohibit public funerals of those dead from such diseases.

CD 13.00 Rules Governing the Approval of Laboratories For Doing Serologic Tests as Required by the Marriage License Law

13.01. For approval a laboratory for this purpose must be under the direction of a licensed doctor of medicine, unless otherwise provided by special action of the State Board of Health, who is a recognized pathologist and who devotes at least half of his time to the supervision of such laboratory.

13.02. Each laboratory must make application to the State Board of Health for approval under this provision.

13.03. If there is a change in the directorship of the laboratory it must be reported to the State Board of Health and the laboratory must reapply for approval.

CD 14.00 Food Poisonings

All instances of food poisoning or suspected food poisoning, in which there is reason to believe that the purchase or consumption of the incriminated food occurred at a store or eating place accessible to the general public, shall be reported.

The Wisconsin State Crime Laboratory

THE Wisconsin State Crime Laboratory is a new state department created by the 1947 Legislature. The laboratory is located in Madison and its purpose is to provide technical assistance to law enforcement agencies in the state, such as the sheriffs, police departments, district attorneys, the attorney general, or the governor.

The statute creating the laboratory specifically prohibits any employee of the laboratory from holding police power, so that the laboratory is not provided to duplicate existing police or enforcement activities on a state level but rather to provide, as a result of examination, analyses, or study of physical evidence or exhibits submitted to the laboratory, technical assistance to those enforcement officers charged with the responsibility of the conduct of criminal investigations.

Some of the specialized technical services rendered by the laboratory are pathology, toxicology, examination of questioned documents, microanalysis, spectrography, firearms identification, applications of radiography and x-ray diffraction, and many other technical services.

The statute creating the laboratory specifically directs that the laboratory's activities be closely coordinated with the research interests of the University of Wisconsin, and in two of the fields mentioned, pathology and toxicology, the laboratory has repeatedly called on Dr. D. Murray Angevine and the men under him in the department of pathology to assist the laboratory with those questions which are submitted to the laboratory which involve death where there is reason to believe that the death under investigation may have resulted from an act of violence or foul play.

In a homicide investigation, one of the first things which must be ascertained with certainty is the cause of death and any contributing circumstances which may be ascertained from a thorough and complete autopsy examination, as well as a detailed examination of the victim's clothing, skin, etc.

In those cases which involve death as a result of gunshot wounds or suspected poisoning or practically any cause of death other than natural causes, in which the district attorney or the coroner have reason to believe that the victim died as a result of foul play, the laboratory attempts, through the active cooperation and participation in such cases of the department of pathology of the University of Wisconsin, to coordinate pathological findings with other technical phases of the investigation which may be of prime importance and concern to either the district attorney or the law enforcement agencies. Supplementing the services that have been mentioned, the laboratory maintains as well equipped laboratories in the matter of equipment and personnel as any laboratory of this kind in the United States. The types of service which are rendered by the laboratory personnel include microscopy, spectrography, x-ray diffraction, soft x-ray technics, the examination of questioned documents, lie detector examinations, the examination of fired bullets and shells, the examination of powder residues on skin or clothing, firearms identification, comparative micrography or the comparison of toolmarks and latent fingerprints, to mention specifically a few of the subjects covered.

It has been our experience that in entirely too many cases involving accidental or violent death, those autopsies which have been made have been made after the victim has been embalmed or that the autopsy has been incomplete or both.

In those cases which involve death as a result of gunshot wounds, it has been found expedient to circulate, in tabular form, among enforcement personnel of the state, a summary of the possible laboratory findings, if the laboratory is supplied with certain exhibits. If the death of the victim is later to become a matter of concern in criminal proceedings, the proper removal, marking for identification, and custody of any and all bullets removed from the victim's body becomes a matter of prime concern to the district attorney and the autopsy surgeon. In addition, the state must be prepared to show that the victim died, beyond any question of doubt, as a result of the gunshot wounds inflicted and not as a result of some extraneous complication.

Fig. 1.—Subject undergoing lie-detector examination (posed photograph).

With the thought that such tabular information might be of assistance to those physicians who may be called upon to perform autopsies in such cases, the information referred to has been reproduced here.

In those cases which involve deaths resulting from automobile accidents, stabbings, etc., it is recommended that at the time of autopsy, a specimen of whole blood be taken and that this specimen be

TABLE 1.—*Firearms Identification; Possible Laboratory Determinations Admissible as Evidence*

EXHIBIT	POSSIBLE LABORATORY DETERMINATION	REQUIRED BY LABORATORY
A FIRED BULLET	Make, Caliber, Type of Firearms from which each could have been discharged; type of propellant used, in firing; name of maker and maker's designation as to type, caliber, etc.	Fired bullets.
B FIRED CARTRIDGE CASE	Make, Caliber, Type of Firearm in which each could have been fired; type of propellant used in firing; name of maker and maker's designation as to type, caliber, etc.	Fired cartridge case.
C TWO OR MORE FIRED BULLETS	In addition to A, whether two or all were fired from the same firearm.	Two or all fired bullets.
D TWO OR MORE FIRED CARTRIDGE CASES	In addition to B, whether two or all were fired from the same firearm.	Two or all fired cartridge cases.
E FIRED BULLET AND SUSPECTED FIREARM	In addition to A above, whether bullet was fired from suspected firearm.	Suspected firearm and fired bullet. See Note 2.
F FIRED CARTRIDGE CASE AND SUSPECTED FIREARM	In addition to B above, whether cartridge case was fired in suspected firearm.	Suspected firearm and fired cartridge cases. See Note 2.
G A FIREARM, AMMUNITION, AND A SCALED PHOTOGRAPH OF POWDER OR SHOT PATTERN	Approximate distance at which shot was discharged.	Scaled Photographs. See Note 2.
H SHOT PELLETS AND WADS	Size of shot, and gauge designation of arm firing wads.	Shot pellets and/or shot wads.

1. Fired bullets, fired cartridge cases or fired shot shells and suspected firearm and any ammunition, together with manufacturers' boxes, if recovered in investigation should be inventoried. These should be submitted to the Laboratory after clearance with District Attorney's office and with superior officer.

2. Consult the Laboratory concerning the making of scaled photographs of powder patterns on victim's skin, doors, walls, etc. If clothing is suspected of containing powder residues they can be wrapped in clean paper or placed in a clean paper bag and preserved. They should be handled as little as possible.

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Hospitals may obtain poster size copies of tables 1 and 2 and Charts 1 and 2 without charge from *Wisconsin Sheriff and Deputy Magazine*, 259 East Wells Street, Milwaukee 2, Wisconsin. It is strongly urged that all Wisconsin hospitals obtain one of these posters to be posted in each operating room and in each emergency receiving room.

TABLE 2.—*Instructions for Handling, Marking, and Shipping Firearms Evidence*

EXHIBIT	GENERAL INSTRUCTIONS	DESCRIPTIVE RECORD TO BE KEPT BY PERSON RECOVERING (NOTE 1)	RECOMMENDED METHOD OF MARKING FOR IDENTIFICATION	INSTRUCTIONS FOR PACKING FOR SHIPMENT TO LABORATORY
A FIREARMS	Check for finger prints. Remove magazine from autoloading weapons. Do not clean or fire. Do not operate mechanism except to unload. If loaded or fired shells in revolver, mark positions. See diagram.	A record of make, model, type, caliber or gauge, designation, serial and lot numbers should be retained by person and agency recovering.	Scratch initials or marks of identification on side of frame, receiver, back strap, barrel, etc. Do not use "X." Do not mark stocks, side plates or part that can be readily removed or replaced.	Place in heavy paper envelope. Forward to laboratory. See Note 4.
B FIRED BULLETS	Every precaution should be taken to prevent abrading or mutilating rifling surface in any way. Do not wash or clean.	Assumed caliber. Notes as to marks of identification. Description of any distinctive features.	Scratch initial on ogive near nose of bullet. Do not use "X." Note 2. If more than one bullet recovered, use initial of person recovering and designate the several bullets by A, B, etc., keeping notes as to source of each.	Wrap in clean cotton or rags. Place in cardboard pill box or rigid container. Do not put in envelope. Mark on container source of each bullet. Forward to laboratory. See Note 5.
C FIRED METALLIC CARTRIDGE CASES	Do not mar, mutilate, scratch or nick head of shell. If recovered in revolver cylinder, mark chambers to correspond with shell designation. See diagram, also note 3.	Notes as to mark of identification used. Head designation of maker. Sketch showing relative position of shells if recovered on floor, street, etc. Transmit this information to laboratory Note 3.	Scratch one initial or mark of identification near mouth of shell, preferably inside of mouth. Do not scratch, nick, mar or multilate head or rear portion of cartridge case.	Roll individually in paper. Place rubber band around paper. Place wrapped cartridges in heavy paper envelope. Forward to laboratory. See Note 5.
D FIRED PAPER SHOT SHELLS	Do not mar, mutilate, scratch or nick head of shell.	Notes as to mark of identification used. Sketch showing relative position of shells when recovered, if shells recovered on floor, street, etc. Transmit this information to laboratory. Note 3.	With ink or indelible pencil mark inside of mouth of shells using initials of person recovering. Do not scratch, nick, mar or mutilate brass head of shell.	Roll individually in paper. Place rubber band around paper. Place wrapped cartridges in heavy paper envelope. Forward to laboratory. See Note 5.
E SHOT PELLETS	Recover as many as possible. Do not mutilate in removal.	Source and position of recovered pellets. Record of number sent to laboratory. Notes on marks of identification used on seal.	Seal container, marking seal with mark of identification on gummed label seal or on envelope.	Use pill box as shipping container. Place box in envelope, sealing envelope. Indicate source of pellets on envelope. Forward to laboratory. See Note 5.
F SHOT WADS	Recover as many as possible.	Source of wads recovered. Transmit this information to laboratory. Notes on marks of identification used.	Using ink or indelible pencil inscribe initials of person recovering as mark of identification. Do not use "X." Place in envelope, sealing for transmission to laboratory.	Place in paper envelope indicating source on envelope. Forward to laboratory. See Note 5.
G LOADED SHELLS OR CARTRIDGES	If loaded ammunition or fired cartridge cases are recovered in investigation, forward to laboratory. If ammunition maker's boxes recovered, forward to laboratory, marking box for identification.	Source or where found. Head designation of maker. Notes on marks of identification used.	Brass cartridges—Scratch mark on side of case near mouth. Paper shot shells—Use ink or indelible pencil. Mark side of shell. Do not mar, mutilate or nick head of shell.	Roll individually in paper. Place rubber band around paper. Place wrapped cartridge in heavy paper envelope. Forward to laboratory. See Note 4.
H SHOT OR POWDER PATTERNS	If on clothing—send only clothing to laboratory that contains powder, powder residues or bullet or shot penetrations. If on skin, doors, walls, etc., consult laboratory concerning scaled photographs.	Description of garment containing shot or powder patterns. Location of shot or powder patterns if on walls, doors or other immovable objects.	Clothing—Attach tag to each article of clothing, indicating source. Mark lining with ink or indelible pencil. Use initials of person recovering.	Wrap clothing in clean paper Forward to laboratory. See Note 5.

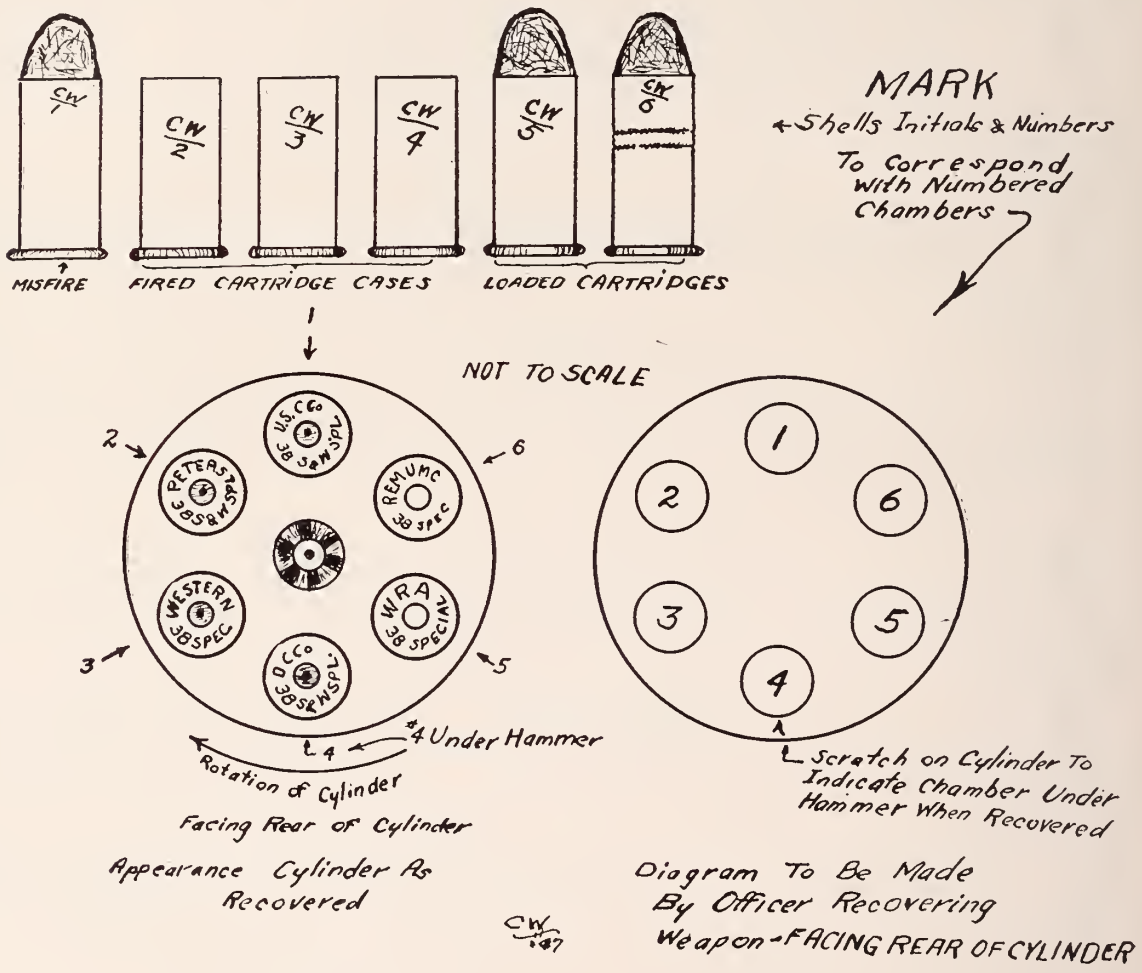
1. Notes should be made covering source, date, place, time and relative position of exhibit at time recovered. Particular method employed in marking for future purposes of identification.
2. Since examination of base of fired bullet may disclose type of propellant used in firing, care should be exercised so as not to disturb powder residues on base.
3. Make sketch of area where shells recovered, indicating relative positions in feet and inches from fixed object.
4. Postal regulations prohibit shipment of explosive substances or firearms through the mails. Ship via express only.
5. After wrapping as suggested, exhibits may be forwarded to the laboratory via messenger, registered mail, or express. Ship in rigid container. Before submitting to laboratory obtain clearance from the District Attorney and superior officer.

SHIPPING INSTRUCTIONS

Before sending these exhibits to the laboratory, clearance should be obtained through the District Attorney's Office and through your superior officer.

MARKING AND PRESERVING THE CHAIN OF EVIDENCE IN GUNSHOT CASES

Charts 1 and 2 Summarize the Important Things for Every Law Enforcement Officer to Keep in Mind When Having Custody of Firearms Evidence Which Later May Be Offered in Evidence Before a Court of Law.



Mark of Identification	*Chamber Position*	*Condition*	*Maker*
CW/1	#1	Misfire	U. S. Cartridge Co.
CW/2	#2	Fired	Peters Cartridge Co.
CW/3	#3	Fired	Western Cartridge Co.
CW/4	#4	Fired	Dominion Cartridge Co.
CW/5	#5	Loaded	Winchester Repeating Arms Co.
CW/6	#6	Loaded	Remington Arms Co.

This information should be preserved since it is possible for the Laboratory to determine the caliber, make and type of propellant or powder used from either a fired bullet or a fired cartridge case. The relative positions of fired cartridge cases in the weapon as recovered then becomes important.

SEE TABLES No. 1 and 2

Chart 1.—Marking Fired Cartridge Cases or Misfired Ammunition Recovered in Revolvers

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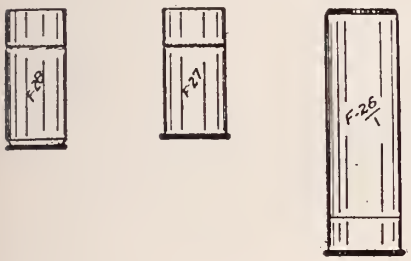
MARKING AND PRESERVING THE CHAIN OF EVIDENCE IN GUNSHOT CASES

In Marking—Use Needle or Sharp Point of a Knife.
Do not use "X" as mark of identification.
Use one or two initials of Officer recovering as mark of identification



LOADED CARTRIDGES—FIRED CARTRIDGE CASES

MARK—INITIAL OF OFFICER Recovering—
On Side of Cartridge Case near Mouth.

DO NOT—Mar or Mutilate Rim, Head or Primer Cup of Fired Cartridge Cases.

PAPER SHOT SHELLS loaded or fired, use either ink or indelible pencil, inscribing initials of Officer recovering on paper tube.

FIRED BULLETS

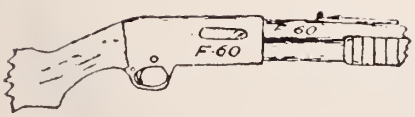
MARK—INITIAL OF OFFICER Recovering—
In Area indicated—Wrap Individually in Paper.

DO NOT—Mar or Mutilate Base, Sides or Cylindrical Portion Containing Rifling Marks.

HAND ARMS—REVOLVERS, AUTOMATIC PISTOLS, SINGLE SHOT PISTOLS

MARK—INITIAL OF OFFICER Recovering—
On Barrel, Frame or Receiver as Indicated .

DO NOT MARK Removable Parts or Stocks.



RIFLES SHOTGUNS, MACHINE GUNS

MARK—INITIAL OF OFFICER Recovering—
On Barrel, Frame or Butt as Indicated.

DO NOT MARK Removable Parts or Stocks.

Chart 2.—Marking Firearms Evidence for Purposes of Identification

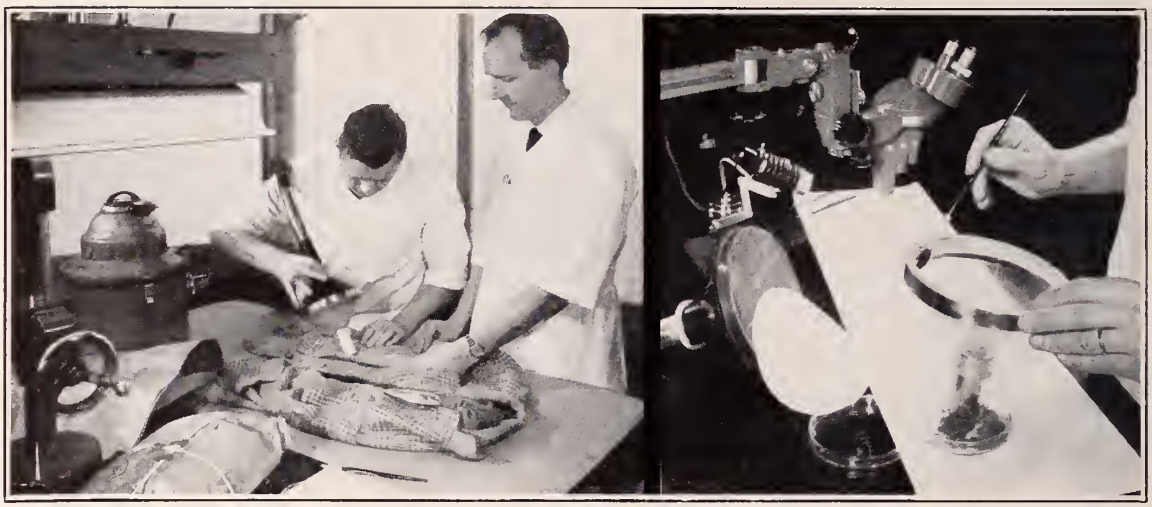


Fig. 2.—*Left,* **an especially constructed vacuum-collecting device is used to recover dust and debris from clothing.** *Right,* **the debris from clothing is placed in a glass dish for examination with the stereoscopic microscope.**

citrated. The quantity required should be approximately 5 cc. The container should be properly sealed and then sent to the laboratory, with the district attorney's knowledge that this has been done.

The value of this specimen becomes apparent when later in the investigation a suspected knife is recovered or a car suspected of having struck the victim is encountered; at this time the blood type of the victim becomes of prime importance in the investigation, if small quantities of blood are recovered from any portion of the car or from the lethal instruments suspected of having been used in the commission of the crime. In too many cases a sample of blood has not been taken at autopsy and, of course, if it is not done at that time, the problem of determining blood type of the victim's blood becomes virtually impossible at some later time.

With the active support and assistance of Dr. D. Murray Angevine of the department of pathology at the University of Wisconsin and Dr. E. L. Tharinger, medical examiner in Milwaukee, it is the hope of the superintendent of the laboratory that a format of conduct will be set forth as a suggested guide when such autopsies are performed, so that adequate materials or specimens are taken at autopsy to insure that no information is lacking at the time a possible judicial inquiry is conducted.

In those cases which involve gunshot wounds inflicted at close range, scaled photographs of both entry and exit wounds should be taken, both before and after the victim is sponged and before the autopsy is actually performed. These scaled photographs, if properly taken, can be of inestimable value later in a possible criminal proceeding.

In those cases in which there is no visible discoloration of the skin due to powder residues or powder "tatooing," as it is sometimes called, powder residues may exist on the victim's clothing. In such cases the clothing should be removed and in the

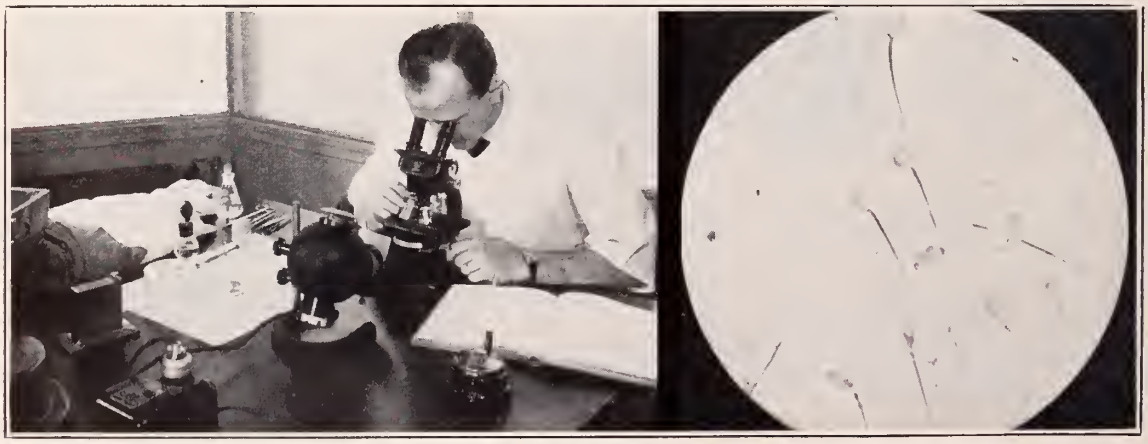


Fig. 3.—*Left,* **The phase contrast microscope is used in the examination of sex offenses cases.** *Right,* **phase contrast photomicrograph showing spermatozoa.**

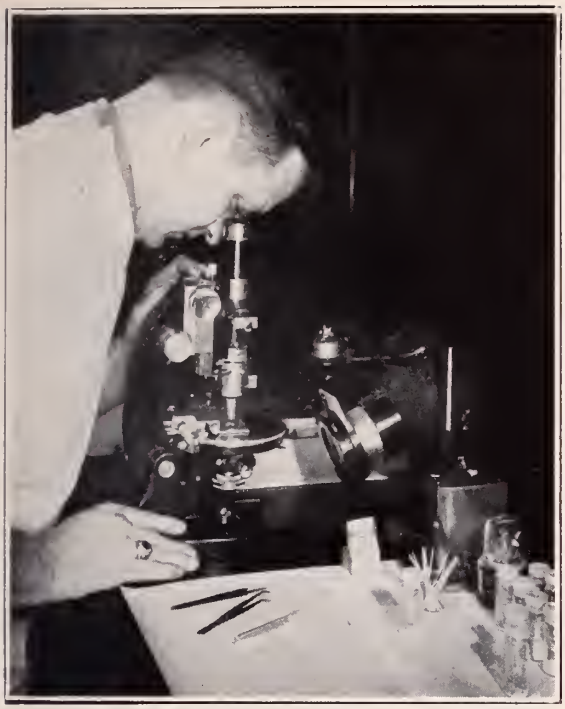


Fig. 4.—The polarizing microscope is used in identifying narcotics and other crystalline materials.

course of such removal it should not be cut through any bullet penetration, either entrance or exit. If it is not too inconvenient, the clothing should be removed without cutting but in some cases this is impractical and it is necessary to cut the clothing in order to remove it from the victim. In such cases it is suggested that the clothing be cut in such a manner so that knife wounds in stabbing cases, or powder residues in the vicinity of bullet penetrations on the clothing be several inches from any cuts which are placed in the fabric, incidental to removal of the clothing from the victim.

In certain types of cases it is desirable to collect, at the time of autopsy, specimens of the victim's head hair. These should be collected by pulling from the scalp rather than by cutting and two sources should be kept in mind. First, some of the longest hairs in the victim's head should be preserved, at least fifty in number, and then a range of colors of the hair should be removed in the suggested manner. This is suggested since later in certain types of investigations it is desirable to have representative specimens of the victim's hair to compare with materials which may be recovered from a suspect, his clothing, his car, etc. If this is not done early in the investigation, experience indicates that it is never done.

In those cases which involve gunshot wounds at close ranges where the projectile has penetrated the victim's clothing, as was recently done in the Patricia Birmingham murder case in Milwaukee, the application of soft x-rays in the examination of the victim's clothing may reveal information of consid-

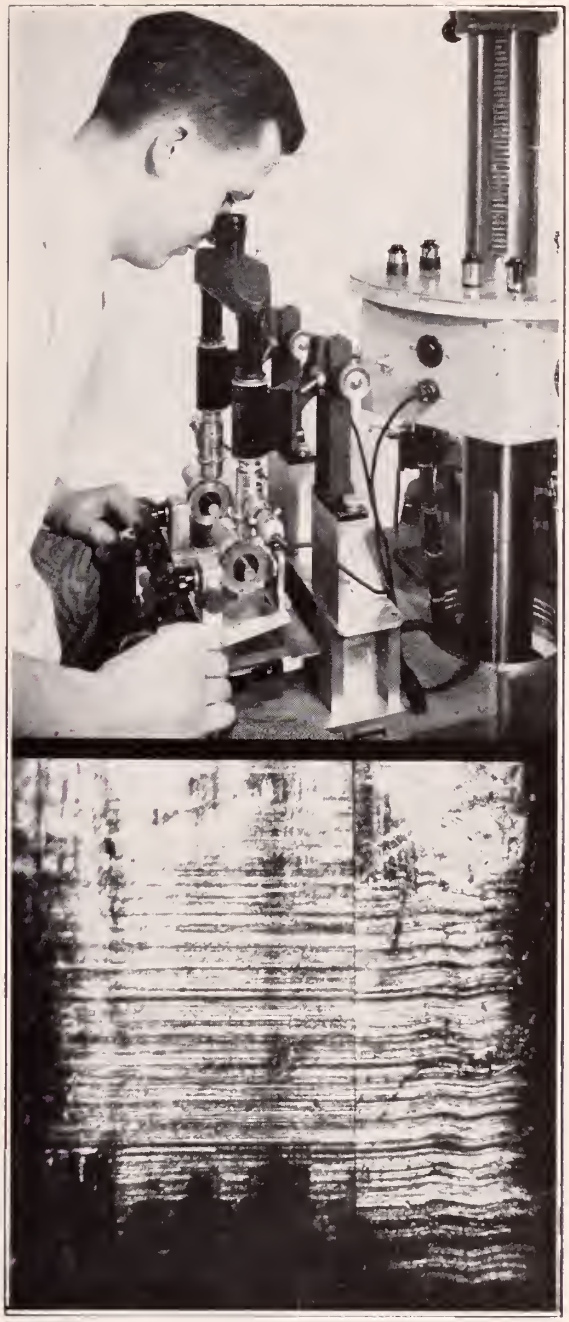


Fig. 5.—*Top*, an especially designed comparison microscope is used in comparing markings on fired cartridge cases and in comparing toolmarks. *Bottom*, a comparison "match" involving extractor marks from two fired cartridge cases obtained with the aid of the comparison microscope.

erable value to the state in establishing the probable facts, if the clothing is made available for examination in the laboratory. In the instant case, metal shearings were blown from the both sides of the revolver in the process of firing the two shots which struck the victim; these particles of metal, which were, of course, opaque to soft x-rays, were imbedded in the fabric of the victim's clothing and, in

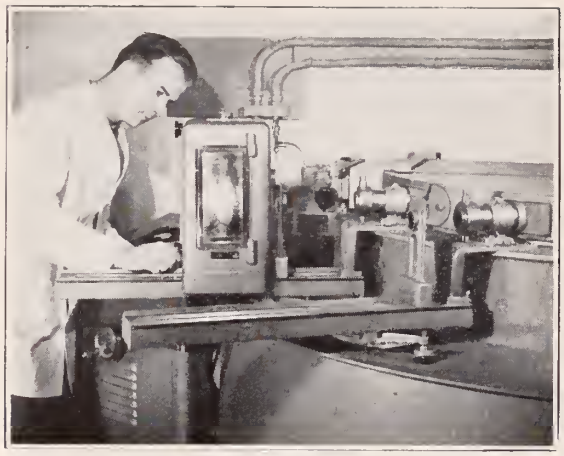


Fig. 6.—Questioned material is examined with the aid of the spectrograph by burning between electrodes, as shown above.

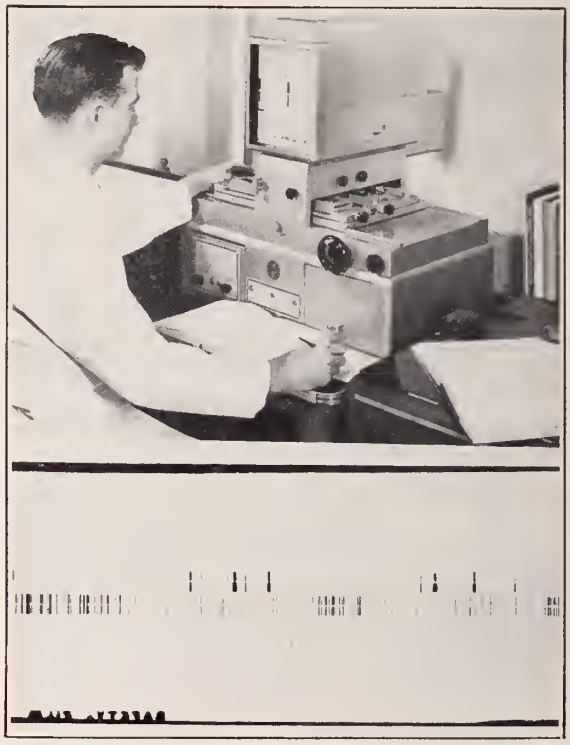


Fig. 7.—*Top*, the chemical composition of the questioned material is determined by comparing the photographic results of the burning of the sample on the comparator densitometer. *Bottom*, an example of the photographic record made while burning a sample of unknown composition. The location and intensity of the lines provides the basis for a qualitative and quantitative analysis.

combination with the powder residues of the skin of the victim's head, established that the weapon was held, at the time the fatal shot was fired, in a position where it was impossible for the victim to have had either hand in contact with the weapon. This was in contradiction to the defendant's statement at the time the case was tried.

The same type of examination may be made to corroborate the findings based on examination of powder residues in the victim's clothing. When a firearm of any type is fired at close range to a victim, powder particles, products of combustion of the powder, and metal shearings are blown from the muzzle of the weapon in the form of a truncated cone, the apex of which is in contact with the muzzle of the weapon and the base corresponding with any place surface such as skin or clothing. Thus by examining the clothing, if the weapon and the fatal bullet are made available, by firing test patterns at known distances, a comparison of the density of the metal or powder residues, the area covered by such residues, a very close approximation as to the interval between the muzzle of the weapon and the victim's clothing or skin at the time the fatal shot was fired can be established by the laboratory technician. This is based on an examination of the fabric and any powder residues which may be retained in the fabric or on the victim's skin. This may be supplemented by a soft x-ray examination to reveal the extent and location of metal shearings which, of course, are opaque soft x-rays which exist in the fabric and which are mixed with the powder gases at the time that the fatal shot was fired. The question of establishing the distance at which gunshot wounds are inflicted becomes in many cases a question of prime importance to the district attorney in any criminal proceedings which may result.

Rather complete and accurate information should be obtained regarding the path taken by projectiles which penetrate the victim's body. If the victim is dead, then an examination should be made to ascertain whether or not there are any unburned grains of powder or partially burned grains of powder which have been blown into the entrance wound or internal organs or tissues. This is particularly true in head wounds.

In cases which involve the charge of rape, a vaginal smear should be taken by the attending physician in all such cases. In addition, as soon as a victim has received medical attention, either in her home or in a hospital, all articles of clothing worn by her at the time of the offense should be removed. Each article of clothing should be placed in a separate, clean, paper bag and not handled any more than is absolutely necessary. Upon receiving authorization from the district attorney, this clothing should be forwarded to the laboratory, together with the unstained vaginal smear. The isolation and identification of spermatozoa in such cases is of considerable importance to the district attorney, and the evidence that has been mentioned should be preserved in the manner that has been suggested.

Clothing removed from victims who have been injured as a result of an assault, a sex offense, or murdered, should be removed with a minimum amount of handling, and each individual article of clothing should be placed in a clean paper bag. The bag should be sealed closed and the district attorney

Fig. 8.—Six containers which have been sealed in the proper manner in order to preserve chain of evidence. It will be noted that strips of adhesive tape are placed over the opening or top of containers. The strip of adhesive tape should then be sealed with a small amount of sealing wax at each end and at the top of the container. While the sealing wax is still molten, a fingerprint of the person sealing should then be pressed into each seal. Upon receipt of containers, technician who is to conduct examination will cut adhesive tape seal, retaining original sealing wax seals intact.

advised that the clothing has been collected and preserved in the manner suggested. The purpose of this is to minimize the possibility of dislodging occupational dirt, debris, hairs, paint fragments, etc., which may be later the object of a searching examination in the laboratory.

Clothing preserved in the manner that has been suggested is cleaned in the laboratory with a special vacuum cleaning device, which is illustrated, and it has been found in burglary cases for instance, that even after a suspect's clothing has been dry cleaned, we were still able to remove safe firewall material which was identified as being identical with the firewall material from the safe which had been opened in the course of the burglary.

In those cases in which it is desired or thought advisable to remove dirt and occupational dirt from the fingernails, it is suggested that a heavy wooden toothpick, one for each nail, be utilized in removing the dirt or debris from the victim's nails and that the ten toothpicks then be placed in a test tube and sealed in the manner that is illustrated in this article.

Although this material may seem to be somewhat detailed, it has, in substance, been given to many enforcement agencies in the state and it is thought that it would be helpful to those members of the medical profession who may be called on to assist the district attorneys, the police, and the coroners with their contributions to the conduct of criminal investigations.

Manual on Scientific and Laboratory Methods of Judicial Proof Now Available

A three-day institute on "Scientific and Laboratory Methods of Judicial Proof" was given by the Wisconsin State Crime Laboratory staff, University of Wisconsin Law and Medical Schools, Office of the Attorney General, and the Bureau of Government, University of Wisconsin in cooperation with the Wisconsin District Attorneys' Association and Wisconsin Bar Association, on October 31, November 1 and November 2, 1951.

The Institute was open to district attorneys and their assistants and judges sitting in courts of record having criminal jurisdiction.

The program included formal lectures and panel discussions involving pathology, legal medicine, toxicology, objective laboratory technics as applied in criminal investigations, the use of tests for alcoholic intoxication, etc.

A 243-page illustrated manual was printed and distributed to those attending the institute. This manual which has since been widely distributed among district attorneys and law enforcement agencies comprises three sections—one, dealing with the functions of the Wisconsin State Crime Laboratory; two, the recovery, marking, and preservation of physical evidence in many types of investigations, and the third section is a rather complete exposition of scientific tests for the determination of alcoholic intoxication.

Dr. Alan R. Moritz, chairman of the department of pathology, Western Reserve University, together with Dr. D. M. Angevine, Dr. A. W. Kozelka, Dr. E. L. Tharinger and Dr. L. J. Van Hecke headed the discussions concerned with pathology, legal medicine and toxicology. Dr. R. N. Harger, professor of biochemistry and toxicology, Indiana University headed the discussions concerned with alcohol. Dr. Hans Reese, professor of neuropsychiatry, University of Wisconsin Medical School, presented a formal discussion entitled "The Use of the Psychiatrist's Findings in Court," and the details of laboratory technics that were included in the program were covered by members of the staff of the Wisconsin State Crime Laboratory.

Physicians interested in obtaining a copy of this manual should write the Bureau of Government, University of Wisconsin Extension Division, Madison, Wisconsin. At the present time only a limited number of manuals are available, but consideration is being given to reprinting them in quantity. The price is $4.00 per copy.

YOUR DEADLINES AND OTHER "MUSTS"

Below are some of the deadlines and "musts" of a practicing physician:

Taxes.

1. File your Wisconsin and federal income tax returns as early in 1952 as possible, *but not later than March 15.*

2. By January 15, 1952, you must pay the final installment of estimated 1951 tax. By this date you must have paid at least 80% of the tax which will be actually due for 1951. If it appears that you will not be within 80%, you may file an amended declaration for 1951 by January 15, 1952, and pay an amount sufficient to bring you within 80%. In lieu of such amended declaration, you may make your federal tax return on that date and pay the full balance due.

3. By January 31, you must:
   (1) File the employer's final return of income taxes withheld in 1951 on Form W–3.
   (2) Furnish a statement to employees on Form W–2 showing wages paid and amount of tax withheld during the calendar year 1951.
   (3) File fourth quarterly return for 1951 of income and social security tax withheld on wages paid employees on Form 941:
      a. If entire tax not paid by timely depositary receipts.
      b. If less than $100 withheld in each of October, November, and December 1951.
   (4) Pay income and social security taxes withheld on 1951 wages to employees:
      a. If more than $100 withheld in December 1951, and not paid to government depositary earlier in January 1952.
      b. If less than $100 withheld in each of October, November, and December 1951.

4. (1) If instructions contained in paragraphs 3 and 4 of Section 2, preceding, are applicable to your situation, make similar quarterly payments and returns on April 30, July 31, and October 31 for the respective preceding calendar quarters.
   (2) If the instructions contained in paragraphs 3 and 4 of Section 2, preceding, are not applicable to your case, in other words, if the total of income and social security taxes withheld on employees' wages exceeded $100 a month and timely deposits for that purpose were made in each of the three preceding months, a quarterly return on Form 941 is due and should be filed on February 10, May 10, August 10, and November 10.
   (3) If income and social security taxes withheld on employees' wages exceed $100 in either the first or second months of each calendar quarter, the amount thereof should be paid to a government depositary by the fifteenth of the following month. The amount of such withheld taxes for the last month of each quarter may either be paid the month immediately following or by the tenth of the second month after the ending of such calendar quarter, as earlier set out in these instructions.

5. The first quarterly estimate of your own income for 1952 is due on March 15. Further estimates are due by June 15 and September 15 of 1952 and January 15, 1953. On those dates you may also amend your March estimate, if there has been a substantial change in your income. By January 15, 1953, you must have paid at least 80% of the tax which will be actually due for 1952. If it appears that you will not be within 80%, you may file an amended declaration for 1952 by January 15, 1953, and pay an amount sufficient to bring you within 80%. In lieu of such amended declaration, you may make your federal tax return on that date and pay the full balance due.

Annual Registration in Wisconsin; Annual Narcotics Registration

1. Register with the Secretary of the Wisconsin State Board of Medical Examiners in the month of January. This registration will be on a form furnished by the Board of Medical Examiners.
2. Register as required by the federal narcotics law, and pay the annual tax *before* July 1, 1952. You are subject to penalties for overlooking either the registration or the tax.

Change of Residence:

1. Notify the collector of internal revenue to insure the legality of your narcotics license. Penalties are imposed for failure to do this.
2. If you take up residence in another county, record your license and basic science certificate with the county clerk so that no question will arise as in the collection of your fees, or your right to give testimony in a legal proceeding.
3. If you have changed the address or place of residence or professional office or should open an additional office after your annual registration in January, 1952, you must, within 30 days thereafter, notify the Board of Medical Examiners in writing of such change.

Remember to:

1. Make prompt report to the State Board of Health of cancer cases, communicable diseases and others as described in the article on page 40.

2. File with the city health officer or county register of deeds a certificate for all births attended by you within five days of the event. Otherwise your medical fees are unlawful. Sec. 69.30, statutes.

3. Register with the county judge if you desire reference work on commitment proceedings for persons allegedly insane, epileptic, inebriate, mentally deficient, and drug addicts. Registration is limited to physicians who have practiced for two years, or have had one year's experience in a hospital for the insane. Sec. 51.01 (2), statutes.

4. Notify the next of kin or a person who may be chargeable with the funeral expenses before you send, or cause to be sent, the corpse of any deceased person to a funeral director, undertaker, mortician or embalmer. The penalty is severe for failure to do so. Secs. 156.14; 156.15 (1), statutes.

5. Report immediately to the local health officer in writing the name, age, and address of every person diagnosed as afflicted with "epilepsy or similar disorder characterized by lapses of consciousness". Section 146.23 (2), statutes.

6. Report *immediately* the following deaths, as required by Section 366.20, statutes, to the sheriff, police chief, or coroner of the county in which such death occurred:

   a. All deaths in which there are unexplained, unusual, or suspicious circumstances.
   b. All homicides.
   c. All suicides.
   d. All deaths following an abortion.
   e. All deaths due to poisoning, whether homicidal, suicidal, or accidental.
   f. All deaths following accidents, whether the injury is or is not the primary cause of death.
   g. When there is no physician in attendance.
   h. When a physician refuses to sign the death certificate.

TAX DEDUCTIONS FOR HEALTH EXPENSES

Following is a summary of the principal provisions of the state and federal income tax laws relating to the deductibility of health expenses of the tax payer and his immediate family.

1. *Federal Law.* Among the items deductible are medical, dental, drug, nursing, hospital, x-rays, travel directly related to hospitalization, including, in the case of a helpless patient the travel expenses of a parent or another companion. "Premiums for insurance policies which pay hospital, surgical, medical, and related benefits are likewise deductible, as is that portion of the total premium of a health and accident policy which represents such benefits. Premiums for disability or time loss insurance, and for accidental death and dismemberment, are *not* deductible, however." To be deductible, *such expenses must be actually paid*, not merely incurred during the tax year.

Only those health expenses in excess of 5 per cent of the tax payer's adjusted gross income may be deducted. Such expenses are *not* allowable up to an amount equal to 5 per cent of such adjusted gross income. For maximum health deductions and fuller treatment of this subject in the federal statute see the *Wisconsin Medical Journal*, December 1951, page 1207.

2. *Wisconsin Law.* Medical, surgical, dental, hospital, nursing, and other healing services and the cost of drugs and medical supplies incurred by the tax payer on account of sickness or of personal injury to himself or his dependents are deductible *if paid* during the tax year, for total amounts in excess of $50.00, but not exceeding $500.00. In other words, the first $50.00 of health expenses of a Wisconsin income tax payer and his dependents is not allowable, nor is any excess of such expenses over $500.00. "The same rule set forth above under Federal Law applies to Wisconsin income taxpayers insofar as deductions for health and accident insurance premiums are concerned." This point is also to be found in the income tax article in the *Wisconsin Medical Journal*, December, 1951, page 1207.

Officers of State Boards and Commissions

State Board of Health

Members of the Board

Stephen E. Gavin, M. D., President, Fond du Lac, 1957
Samuel L. Henke, M. D., Vice-President, Eau Claire, 1953
Carl N. Neupert, M. D., Secretary and State Health Officer, Madison, ex officio
William T. Clark, M. D., Janesville, 1956
Carl D. Neidhold, Appleton, 1952
Forrester Raine, M. D., Milwaukee, 1954
Stephen Cahana, M. D., Milwaukee, 1955
Woodruff Smith, M. D., Ladysmith, 1958

Bureaus, Divisions, and Units of State Board of Health

GENERAL ADMINISTRATION

Carl N. Neupert, M. D., State Health Officer
E. H. Jorris, M. D., Assistant State Health Officer

Bureau, Division or Unit

Division of Personnel—Henry Kjentvet, Director
Division of Budgets & Accounts—Fred E. Brown, C. P. A., Director
Division of Laboratories—W. D. Stovall, M. D., Director
Bureau of Vital Statistics—Paul Weis, Assistant State Registrar
Division of Dental Education—Francis A. Bull, D. D. S., Supervisor
Division of Health Education—Ralph Kuhli, Director
Division of Hospital Survey & Construction—Vincent F. Otis, Director
Division of Statistical Services—Vivian B. Holland, Statistician
Division of Cosmetology—Lenore Brandon, Supervisor
Division of Barbering—Dorothy Greene, Acting Supervisor
Division of Funeral Directing & Embalming—Helen Kjelson, Supervisor

Section on Preventable Diseases

Milton Feig, M. D., Director
Bureau of Communicable Diseases—Milton Feig, M. D., Director
Bureau of Tuberculosis Control—Pierce D. Nelson, M. D., Director
Division of Venereal Disease Control—A. L. Van Duser, M. D., Director
Division of Cancer Control—A. L. Van Duser, M. D., Director
Division of Heart Disease Control—Pierce D. Nelson, M. D., Director

Section on Environmental Sanitation

O. J. Muegge—State Sanitary Engineer
Harvey Wirth—Assistant State Sanitary Engineer
Division of Plumbing—Walter Spencer, Supervisor
Division of Well Drilling and Ground Water—Thomas Calabresa, Supervisor
Division of Rendering and Slaughtering—Arthur F. Rizzi, Supervisor
Water Pollution—T. F. Wisniewski, Director
Milk Sanitation—C. K. Luchterhand, Sanitarian

Section on Maternal and Child Health

Amy Louise Hunter, M. D., Director
Bureau of Maternal and Child Health—Amy Louise Hunter, M. D., Director
Division of Mental Health—Eugenia S. Cameron, M. D., Director
Nutrition—Lucile K. Billington, Supervisor

Section on Local Health Administration

Allan Filek, M. D., Director
Division of Local Health Administration—Allan Filek, M. D., Director
Bureau of Public Health Nursing—Janet Jennings, R. N., Director
Division of Industrial Hygiene—William L. Lea, Director
Division of Hotels and Restaurants—Harold E. Olsen, Supervisor

District Health Offices

No. 1—602 Insurance Building, Madison

Health Officer: (Vacancy)

Counties included: Crawford, Richland, Sauk, Columbia, Dane, Green, Lafayette, Iowa and Grant

No. 2—Municipal Building, Elkhorn

Health Officer: Elmer E. Bertolaet, M. D.

Counties included: Jefferson, Rock, Waukesha, Walworth, Milwaukee, Kenosha and Racine

No. 3—Court House, Fond du Lac

Health Officer: Donald Engels, M. D.

Counties included: Winnebago, Sheboygan, Calumet, Dodge, Manitowoc, Washington, Fond du Lac and Ozaukee

No. 4—City Hall, P. O., Box 251, Sparta

Health Officer: John A. Van Susteren, M. D.

Counties included: La Crosse, Waushara, Green Lake, Monroe, Juneau, Vernon, Adams and Marquette

No. 5—City Hall, P. O. Box 270, Wisconsin Rapids

Health Officer: (Vacancy)

Counties included: Pepin, Clark, Buffalo, Wood, Trempealeau, Marathon, Jackson and Portage

No. 6—City Hall Annex, Box 383, Green Bay

Health Officer: G. M. Shinners, M. D.

Counties included: Waupaca, Kewaunee, Shawano, Door, Oconto, Brown, Marinette and Outagamie

No. 7—417½ North Bridge Street, Chippewa Falls

Health Officer: R. E. Graber, M. D.

Counties included: Polk, Dunn, Barron, Rusk, Chippewa, Pierce, St. Croix and Eau Claire

No. 8—City Hall, Rhinelander

Health Officer: Frances Cline, M. D.

Counties included: Taylor, Price, Lincoln, Oneida, Forest, Vilas, Florence and Langlade

No. 9—Vaughn Library Building, Ashland

Health Officer: (Vacancy)

Counties included: Douglas, Bayfield, Burnett, Washburn, Ashland, Sawyer and Iron

State Board of Public Welfare

(Created by act of 1939 legislature to supplant the State Board of Control and combine certain other agencies)

Members of the Board

William Studley, M. D., Milwaukee, 1953
Mr. Harold W. Story, vice-chairman, Milwaukee, 1957
Mrs. Harrison L. Garner, Madison, 1953
Mr. Ralph Uihlein, Milwaukee, 1957
W. D. Stovall, M. D., chairman, Madison, 1955
Mrs. Karl Kleinpell, Cassville, 1955
Mr. Leo Jelinske, Shawano, 1955
Mr. Earl M. Hale, Eau Claire, 1953
Mrs. C. R. Beck, secretary, West Allis, 1957

Executive Staff

Mr. John W. Tramburg, Madison, Director
Mr. A. W. Bayley, Madison, Deputy Director

Division of Corrections
Mr. Russell G. Oswald, Madison, Director

Division of Mental Hygiene
Leslie Osborn, M. D., Madison, Director

Division of Public Assistance
Mr. George M. Keith, Madison, Director

Division of Business Management
Mr. Wilbur Schmidt, Madison, Director

Division for Children and Youth
Mr. Frederick DelliQuadri, Madison, Director

Basic Science Examiners

Prof. Michael F. Guyer, President, Zoology Department, University of Wisconsin, Madison, 1955
Prof. W. H. Barber, Secretary, Ripon College, Watson and Scott Streets, Ripon, 1957
Prof. H. M. Weeks, Superior State College, Superior, 1953

State Board of Medical Examiners

A. F. Rufflo, M. D., President, United States Bank Building, Kenosha, 1953
J. W. Smith, M. D., 324 East Wisconsin Avenue, Milwaukee, 1955
E. W. Miller, M. D., 231 West Michigan Street, Milwaukee, 1953
H. H. Christofferson, M. D., Colby, 1953
Alvin G. Koehler, M. D., Secretary, 46 Washington Boulevard, Oshkosh, 1955
J. W. Prentice, M. D., 522 West Second Street, Ashland, 1955
E. C. Murphy, D. O., 314 East Grand Avenue, Eau Claire, 1953

Wisconsin Industrial Commission

Members of the Commission

Mr. Voyta Wrabetz, Chairman, 1955
Mr. Harry J. Burczyk, 1953
Mr. C. L. Miler, 1957
Miss Helen Gill, Secretary

Workmen's Compensation Department
Mr. Harry A. Nelson, Director

Unemployment Compensation Department
Mr. Paul R. Raushenbush, Director

Safety and Sanitation Department
Mr. O. T. Nelson, Director

Woman and Child Labor Department
Maud Swett

State Board of Vocational and Adult Education

E. J. Fransway, Employee member_____Wauwatosa
Emil Waldow, Employee member_____Green Bay
Frank C. Horyza, Employee member_____Superior
Alfred A. Laun, Employer member_____Kiel
Robert L. Pierce, Employer member_____Menomonie
Morton Frost, Employer member_____Kenosha
John Last, Farmer member_____Lake Mills
T. E. Hamilton, Farmer member_____Westfield
Elmer Wilkins, Farmer member_____Platteville
G. E. Watson, ex officio_____Madison
Voyta Wrabetz, ex officio_____Madison
C. L. Greiber, ex officio_____Madison

State Director, State Board of Vocational and Adult Education

Rehabilitation Division

State Supervisory Staff

Room 320, State Office Building, Madison

(Vacancy) ——————————————Chief
J. H. Brown——————————Assistant chief
Charles Beardsley——————Case Service
Irene M. Dunn—Finances and Mentally Handicapped
A. E. Towne——————————Medical Service
Mary F. Beyer——————————Homecraft
Edward J. Pfeifer————Psychological Service
A. W. Bryan, M. D.————Medical Consultant (part time)
Inez F. Belyea————Social Work Supervisor (half time)
Mrs. Thelma Peckham——————Statistician

District Offices

Madison——Vocational School Building, 211 North Carroll Street
C. D. Rejahl, District Supervisor
Milwaukee Vocational School Building, 1015 North Sixth Street
L. A. Rumsey, District Supervisor
Green Bay Vocational School Building, 200 South Broadway
A. W. Bouffard, District Supervisor
Eau Claire——————314 East Grand Avenue
F. A. Campbell, District Supervisor

Local Offices

La Crosse Vocational School Building
Carl J. Haase, Case Supervisor
Racine Vocational School Building
V. C. Bryan, Case Supervisor
Wausau Vocational School Shop Building
L. J. Schultz, Assistant Case Supervisor
Superior——————————917 Tower Avenue
H. C. Ritzman, Case Supervisor

STATE MEDICAL ADVISORY COMMITTEE

T. J. Howard, M. D.——————————Milwaukee
G. F. Wakefield, M. D.——————West Salem
J. S. Supernaw, M. D.——————————Madison
R. M. Kurten, M. D.——————————Racine
H. L. Greene, M. D.——————————Madison
H. M. Coon, M. D.——————————Madison
C. N. Neupert, M. D.——————————Madison
Charles Fidler, M. D.——————Milwaukee
H. H. Reese, M. D.——————————Madison
H. J. Heeb, M. D.——————————Milwaukee
Harry D. Bouman, M. D.——————Madison
R. W. Thompson, M. D.——————Madison
Miss Marjorie Taylor——————Milwaukee
Miss Janet Jennings——————Madison

DEATH CERTIFICATES

The Attorney General, in a recent opinion to the State Health Officer, clarifies the role of the physician in making and signing death certificates. The physician last in attendance on the deceased is required to make and sign the certificate. In the absence of an attending physician, however, one called in for the purpose may properly refuse to certify if he does not have the necessary information.

The Opinion ruled that, under those circumstances, when a physician refuses to certify as to the cause of death, the person wishing to dispose of the body must arrange for the physician to make the necessary investigation of the cause of death and pay him for such investigation. That cost is a necessary part of burial expense in view of the fact that a complete and satisfactory death certificate is required before a burial or removal permit can be obtained.

A coroner may make and sign a death certificate only where an inquest has been held. The local registrar may likewise certify only when a physician cannot be obtained early enough.

PRESCRIPTION OF NARCOTICS

The question has been asked whether a physician may legally write a prescription for narcotic drugs on the representation of a person other than the patient in a situation in which the physician does not know and has not actually seen the supposed patient.

The question must be answered with a strong negative. Before narcotics can be prescribed, first, the physician must know that a particular patient exists; second, he must also know, on the basis of examination and diagnosis, that the particular patient needs narcotics or a medicine containing narcotics. The recital of a person other than the patient to the physician is not enough, and the physician who prescribes narcotics for a person he does not know to exist violates the law. See articles on this subject in *The Wisconsin Medical Blue Book*, pages 47 and 50.

Physicians are cautioned never to prescribe narcotics for a patient unless by examination and diagnosis the patient is known to exist and until a need for narcotics has been verified.

THE MEDICAL FORUM

A. M. A. CHARGES "POLITICS" IN TRUMAN HEALTH STUDY

Farm Bureau Fights for "American Way"

Chicago, Jan. 1.—Leaders of the American Farm Bureau Federation, meeting in Chicago last month for their annual session, promised that agriculture will not default on its responsibilities for the continuation of the "American Way."

"Stop Socialism" and "Preserve Freedom" were the keynotes of the association which has grown into the world's largest farm organization in the last 33 years.

Nearly 200 Farm Bureau members from Wisconsin attended. They heard Sen. Harry F. Byrd, Virginia, attack the administration's welfare state.

"Mr. Truman says it is an insult to the intelligence of the American people to say this country is on the road to socialism. I submit that it is an insult to our intelligence to assume that we do not realize that adoption of the President's program will commit us irrevocably to a socialistic state, from which there can be no retreat."

President Allan B. Kline of the American Farm Bureau said, "We are being urged in the name of 'emergency' to desert the proven success of the great American experiment, and to substitute unlimited federal authority in the economic field."

Dr. Dietz Takes Civil Defense Post

La Crosse, Dec. 15.—Dr. Paul C. Dietz, La Crosse, has accepted the post of Area Medical Director in Civil Defense Area No. 5 with headquarters in La Crosse.

Four mobile medical teams are being mustered in La Crosse and another in Sparta.

This brings the total number of mobile medical teams in Wisconsin to over 100. It is believed that this number will be sufficient, at least during the initial stages of civil defense planning.

24 Wisconsin M.D.s Attended AMA Session

Chicago, Jan. 8.—Final tabulation of the registrations at the Clinical Session of the American Medical Association in Los Angeles, Dec. 4–7, shows that 24 Wisconsin physicians attended the meeting. They were:

R. G. Arveson, Frederic
M. M. Baumgartner, Janesville
E. L. Bernhart, Milwaukee
H. P. Davis, Madison
G. J. Egan, La Crosse
C. H. Falstad, Eau Claire
J. M. Fine, Cudahy
S. E. Gavin, Fond du Lac
J. C. Griffith, Milwaukee
Gunnar Gundersen, La Crosse
H. A. Heise, Milwaukee
W. B. Hildebrand, Milwaukee
T. L. Johnston, Milwaukee
H. C. Kappus, Kenosha
J. F. Kovacic, Sheboygan
J. C. Moore, Madison
M. H. Olson, Wittenberg
J. C. Sargent, Milwaukee
O. E. Satter, Prairie du Chien
A. E. Schultz, Madison
D. J. Twohig, Fond du Lac
N. J. Wegmann, Milwaukee
D. H. Witte, Milwaukee
M. E. Wyant, Hayward

Dr. Engels Takes Over Health Officer Duties

Fond du Lac, Jan. 2.—Dr. Donald Engels has accepted the position of health officer of State Board of Health District No. 3 and now has his headquarters at Fond du Lac.

Dr. Engels was discharged from the Army last September after 26 months of service of which 13 was spent as medical officer in Korea.

He is a graduate of Marquette University School of Medicine and interned at Evangelical Deaconness Hospital, Milwaukee. His general residency was served at St. Lawrence Hospital, Lansing, Michigan.

Chicago, Jan. 7.—Wisconsin physicians were more than interested when the New Year brought the appointment, by President Truman, of a commission to study the nation's health needs. Dr. Gunnar Gundersen refused a post on it.

As expected, liberal papers and leaders reacted vigorously. Reprinted below are the comments of Dr. George F. Lull, secretary and general manager of the American Medical Association, as published in his weekly "Secretary's Letter":

Dear Doctor:

Well, here we go again—

The President has just named a commission to study the nation's health needs, including his own proposals which he has been advocating since 1945, and urged it to come up with a report within a year or sooner.

The President announced the names of 15 prominent lay and professional persons who will serve on the commission. Dr. Paul B. Magnuson, prominent Chicago orthopedic surgeon, was chosen to head the group.

Also on the commission's list, when it was handed to newspapermen in Washington, was Dr. Gunnar Gundersen, La Crosse, Wis., a member of the A.M.A. Board of Trustees. But within 24 hours, Dr. Gundersen repeated the words of Samuel Goldwyn and informed the President that he "would have to include me out." Then he issued the following statement:

"At the time I was invited to serve on the President's new commission to study health problems, I felt it most important to see his statement of objectives.

"I have not yet received such a directive, but judging from statements released to Washington press representatives by spokesmen for the President, I believe I am correct in assuming that the commission is designed, both in its majority membership and in its objectives, as an instrument of prac-

(Continued on page 70)

DR. GUNDERSEN . . .

(Continued from page 69)

tical politics, to relieve President Truman from an embarrassing position as an unsuccessful advocate of compulsory health insurance.

"I certainly cannot subscribe to such a masquerade and today have requested that my name be removed from consideration as a commission member."

"Not Common Sense"

Dr. Gundersen felt as most informed physicians do that such a study was unnecessary. Scores of studies have been made in the past, including Mr. Ewing's big national health assembly which was held in Washington. The new study is to be financed with defense funds, leading people to believe that an emergency exists.

Why should such a study be undertaken with defense funds? The answer may be in "Alice in Wonderland"; it certainly isn't in the book of common sense.

This is reflected in the statement which A.M.A. President John W. Cline, San Francisco, gave to the press the day after Dr. Gundersen resigned from the commission. Dr. Cline said the President's action in creating the commission and having its work financed with emergency funds allocated for national defense represents another flagrant proposal to play politics with the medical welfare of the American people.

"Brazen Misuse of Funds"

"This," he added, "is a shocking attempt to give White House sanction to the brazen misuses of defense emergency funds for a program of political propaganda, designed to influence legislation and the outcome of the 1952 election."

Dr. Cline said there was "no health emergency" to require "the investigation or the expenditure of defense emergency funds.

"The health of the American people never has been better, as all competent authorities know, and greater progress is being made in providing prepaid medical care for all who need or desire it than at any other time in history."

Dr. Cline called "any attempt to whip up an asserted health 'emergency' as an excuse to create another tax-supported commission is an outrageous abuse of public authority."

In brief, Dr. Cline believes the President's latest political move amounts to a big nothing.

The President directed the commission, whose membership includes such men as Dr. Dean A. Clark, Walter P. Reuther and Clarence Poe, editor of the Progressive Farmer, to inquire into and study the following:

1. Present and prospective supply of physicians, dentists, nurses and other medical people and the ability of schools to provide what is needed.
2. The ability of local public health units to meet the demands of civil defense requirements.
3. Problems created by the shift of workers to defense-production areas which would require relocation of medical personnel.
4. How existing and planned medical facilities meet present and prospective needs.
5. Present research activities in the field of health and the research program needed.
6. The effect on maintaining health standards of actions taken to meet long-range military, civil-defense and veterans requirements.
7. The adequacy of private and public programs designed to provide ways to pay for medical care.
8. How much the government should contribute to local governments for health purposes.

The President's attempt, by the appointment of another commission, to take the issue of health out of the 1952 political arena has been unmasked and shaken by the Cline–Gundersen statements.

Sincerely yours,
GEORGE F. LULL, M.D.
Secretary and General Manager

You Can Find Dues Facts in January 12 JAMA

Chicago, Jan. 14.—AMA members having any questions about dues shouldn't overlook the lengthy article, "Facts About AMA Dues for 1952," which appears in the Organization Section of the January 12th issue of the Journal of the AMA. The facts are provided so as to answer any questions which doctors might have about dues.

Appoint Committees for Commission on Prepaid Plans

Madison, Jan. 18.—Dr. E. M. Dessloch, Prairie du Chien, chairman of the medical society's Commission on Prepaid Plans, has announced the completion of the committee structure of the commission.

An executive committee, created by direction of the general Council of the society, includes Dr. Dessloch and Drs. H. E. Kasten, Beloit; R. H. Krohn, Black River Falls, and J. S. Supernaw, Madison.

Other appointments are as follows:

Claims: Drs. C. G. Reznichek, Madison, chairman; N. A. Hill, Madison and John Sprague, Madison.

Enrollment and Underwriting: Drs. R. E. Garrison, Wisconsin Rapids, chairman; Richard Foregger, Milwaukee; Charles Fidler, Milwaukee, and R. M. Moore, Frederic.

Research and Development: Drs. P. B. Mason, Sheboygan, chairman; K. H. Doege, Marshfield; H. A. Aageson, Oconto; T. D. Elbe, Thiensville, and J. W. Truitt, Milwaukee.

Physicians and Public Relations: Drs. G. W. Carlson, Appleton, chairman; Milton Finn, Superior; H. B. Christianson, Superior, and W. C. Stewart, Kenosha.

Blue Cross: Drs. Dessloch, Reznichek, Garrison, Mason and Carlson. Each is chairman of one of the committees of the Commission.

The Commission held its first meeting on Dec. 15–16. At that time plans were developed for placing the new Wisconsin Plan and Wisconsin Physicians Service benefit and fee structures into operation about mid-year.

Chicago Medical Society Offers $1000 Award for Medical Care Ideas

Chicago, Dec. 3.—Offer of an award of $1,000 to the resident of Cook County submitting the best plan for improving medical care was announced today by the Chicago Medical Society.

The offer is open to any resident of Cook County except physicians and their families and employees.

Health Issues Loom Large in Second Session of 82nd Congress

Washington, D. C., Jan. 15.—In the first days of the second session of the 82nd Congress it appears that there will be much talk, little legislation passed, and early adjournment.

But with each passing day there are indications that health legislation is achieving greater political potency. Chances are that only one or two major health bills will be enacted, but the subject of health is certain to be debated with increasing fervor.

Shortly before the session began, President Truman announced his "President's Commission on the Health Needs of the Nation." Dr. Gunnar Gundersen's appointment and immediate resignation evoked strong praise and criticism, depending upon the source.

The American Medical Association called it a "stacked" commission "palpably political in its design." Dr. John W. Cline, president of the AMA, pointed out that President Truman's commission is supposed to accomplish its enormous survey within one year (an election year) although the Hoover Commission took a year-and-one-half on a study of federal medical services alone. The Brookings Institution took three years for its study of the nation's health, and the Commission on Financing of Hospital Care, just established, plans on three years.

On January 9, President Truman reaffirmed his liking for national health insurance. But instead of asking for its adoption by Congress, as he has done in past years, he limited his request to enactment of two measures—expansion of aid to local public health departments and granting of federal assistance to medical schools.

With this as a background, work on S. 337 (Aid to Medical Education) and S. 445 (aid to local public health units) is being resumed and plans being discussed to expedite their passage.

The AMA is opposed to S. 337 because it fears federal control of schools, curricula and students, undue emphasis on quantity rather than quality in production of physicians.

S. 445 has been supported by the AMA in all except minor details. The Senate passed this bill, House committees have held hearings, and it is now waiting to be reported out.

Legislation for financing medical care for dependents of enlisted men in the armed forces (EMIC) is still in committee, but early hearings are expected.

Also scheduled for consideration, but not yet introduced in either House, is the Ewing plan for hospitalization-at-age-65 at public expense.

Because of next fall's elections, developments on these four measures will be watched with particular interest by physicians.

Other straws in the wind are Governor Warren's entrance into the presidential arena (he favors a national system of "prepaid medical care") and organized labor's efforts to line up the AFL and strong independent unions with the CIO for a militant campaign on behalf of national compulsory health insurance."

Ewing Asks Blue Cross to Handle Care of Aged

Washington, D. C., Jan. 4.—To meet some of the opposition to his plan for government hospitalization of aged persons, Federal Security Administrator Oscar Ewing has adopted a so-called "grass roots" approach to the problem.

He is proposing now that such hospitalization be provided through voluntary organizations, such as Blue Cross. Tentative legislation has been drafted and discussed with officers of voluntary plans and hospitals, it is reported.

Covers 7 Million

Ewing claims his hospitalization project is "not a substitute for national health insurance. It's a segment. We picked out a part of this whole program that needs something the worst."

He estimates the total cost of operation for 1953, the first year, at $200 million. About 7 million persons would be eligible, 5½ million of them over 65 and the others dependents of persons covered by Old Age and Survivor's Insurance.

La Crosse and Viroqua Get Hospital Grants

Washington, D. C., Dec. 15.—Two new hospital projects in Wisconsin have been approved for Hill–Burton grants, according to a report supplied by the Washington Office of the American Medical Association.

Dr. Joseph S. Lawrence, director of the office, relayed information that the Division of Hospital Facilities of the Federal Security Agency had approved federal grants of $320,562 for construction of a 68-bed addition to La Crosse Lutheran hospital, and $69,399 for 17 beds at the Vernon Memorial Hospital in Viroqua. The total cost of each facility is $738,033 and $154,220, respectively.

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NORWAY AND SWEDEN—AN ELDORADO FOR BUREAUCRATS

Norway and Sweden are often held up as "glowing examples" of "socialized medicine." They are often mentioned in debates on the issue of compulsory health insurance. This is the first of a series of articles on medical care and conditions in the Scandinavian countries as prepared for the *Medical Forum* by Dr. Gunnar Gundersen, La Crosse, member of the Board of Trustees of the American Medical Association.

La Crosse, Jan. 1.—My purpose in visiting the Scandinavian countries last August, September and October was to represent the American Medical Association as one of its two delegates to the annual World Medical Association meeting in Stockholm, Sept. 15–20. Dr. Edward S. Hamilton, Chicago, was the other delegate. Alternate delegates were Dr. J. J. Moore, Chicago, treasurer of the AMA, and Dr. Austin Smith, editor of the Journal of the AMA.

Many American physicians attended—in particular, Dr. Elmer L. Henderson, Louisville, Ky., retiring president of the W.M.A.; Dr. Louis H. Bauer, Hempstead, N. Y., secretary-general of the W.M.A.; Dr. Roscoe Sensenich, South Bend, Ind., council member; Dr. Morris Fishbein, New York, editor of the W.M.A.'s publications, and several other official and non-official observers.

First Visit in 28 Years

Mrs. Gundersen and I travelled over on the M.S. Oslofjord, a new and comfortable boat of 16,000 tons. First port of call was Copenhagen, Denmark, where we spent one day sightseeing. Then to Oslo for three days and a motor trip through the western fjord country of Norway as far west as Bergen. We had not been in Norway for 28 years so a great deal of the time was spent in renewing acquaintances. Following our stay in Norway, we went to Sweden, arriving in Stockholm on September 14. After the W.M.A. annual meeting we returned to Norway for an additional week prior to returning to this country. We had planned to return by boat, but being reminded of the beauties of Wisconsin during the first two weeks of October, we were taken with acute homesickness and elected to return by air. We arrived home on October 2, amply rewarded by a beautiful Indian summer.

DR. GUNDERSEN

I would like to make some general observations, those which a visitor to these countries would make after an absence of almost one generation. Sweden, as you know, has weathered two World Wars without becoming directly involved. Consequently, the conditions in Sweden are perhaps quite different from those in the other Scandinavian countries, Denmark and Norway. I am more familiar with the Norwegian situation, consequently I shall speak of that first.

During the first World War Norway succeeded in not becoming involved. The Norwegians have always traded largely to the West and their sympathies have usually been predominantly with the English-speaking nations, although there has always been a large element, but not more than 50%, who were inclined to the German point of view.

This is not true in Sweden, whose sympathies even in the first World War, I believe, were predominantly on the side of the Central Powers, and this continued even during the second World War, when through force of circumstances it was necessary for them to play both ends to the middle. However, in Sweden there has developed a genuine distrust of anything German, and I think now that things have changed to a point where the people generally would rather go along with the Atlantic Pact Powers than throw their fortunes with Germany.

Their fear of the Russian Bear, of course, perhaps necessitates this point of view. Formerly, for instance, German was probably their foreign language of choice, whereas now most people have a speaking knowledge of English or at least have a reading knowledge. English is a compulsory foreign language in all schools.

Mistrust Germans

In Norway things have changed to a point where America and England, particularly, are their countries of choice, and they have developed such a thorough dislike and mistrust of anything German that I think it will take at least a generation before the ill-will engendered by Germany as a result of the War will be overcome.

Sweden is by all odds the more potent of the two countries, being the larger from the population point of view, having approximately 6 million or more inhabitants. It is a proud country, rich in tradition, rich in natural resources, agricultural, mineral, and industrial.

Socialist Minded

Norway, with its 3 million people, has a quite different economy. Norway is a factor in the world market when it comes to shipping, the country standing about fourth as far as world tonnage is concerned. Their other economies are mineral wealth, approximately 10% of the world's supply of aluminum being produced there. In addition to this, of course, there are abundant natural resources in the form of water power.

And certainly not of least importance is Norwegian fishing. They have developed new techniques in fishing, especially in reporting impending schools of fish so that fishing is now carried on in a much more scientific manner and consequently much more productive. Timber is also an important industry, most of the timber being converted into pulp, and I might say, of a very high quality.

OSLO—CAPITAL OF NORWAY. This city is the largest port and greatest in population. City hall is in center, University at left. Norwegians are proud of modern buildings, including hospitals and health centers.

As far as governments are concerned, both countries are constitutional monarchies, both have parliamentary forms of government, and the King in each is pretty much a figurehead. The countries have paralleled each other as far as their liberal tendencies are concerned, and have been definitely socialistic for the past many years.

Even Communism had a large following, but of recent years this philosophy of government is becoming more and more unpopular through, I presume, their fear of Russia. The Communist trend is definitely downward, whereas there has been no appreciable change in respect to their socialistic ideologies, although I sensed a more conservative trend lately. Many of the people were hopeful that there would be some change or swing to the right.

Norway and Sweden have not joined in any common defense alliance. Sweden, as I understand it, is not yet a member of the Atlantic Pact Organization. Norway consequently finds itself in a position where the citizens feel that they are spending a disproportionately large amount of money for defense purposes. A great deal of the Marshall Aid, for instance, is being used for this purpose, and practically all of the money is being funnelled into the country through governmental agencies and used for governmental purposes in reconstruction and the like.

Private enterprise has seen little or none of this money. This seems to be a source of dissatisfaction as far as the people who are exponents of the private enterprise system are concerned.

In the socialistic economy of Norway, the people are heavily taxed. I was led to believe that 40% of the national income is swallowed in the form of taxation. A steeply-progressive income tax is in effect so that no one can really have anything to himself after the Government gets its cut.

For instance, a man with a 1 million kroner income, which roughly is $150,000 a year, has only 50,000 kroner left, which in our money is not more than $7,000. You can readily understand how people who are heads of industries and so on, feel about this situation.

In the lower income groups it affects itself in a way that it is practically impossible for anyone to have for his own purposes, more than 10,000 kroner a year, or approximately $1,300 at the present rate of exchange.

The consequence of this is that the more a person works, the less he is rewarded, and as far as the laboring population is concerned, it is difficult to get an ordinary workman to put in more than four days a week. He feels that working more than this simply means a contribution to the support of the State, which he is unwilling to do.

People Frustrated

Timber or forestry workers, for instance, get out on Tuesday morning and work through Friday, which is not more than a four-day week. Any time spent in overtime work and extra time simply results in confiscation of income, and I believe it has gone to a point where it is definitely retarding the country's productivity.

There seems to be a general frustration among the people resulting from this heavy burden of taxation, but as long as everyone finds themselves in the same boat, they seem to be resigned to it, and are making the best of it.

In Norway, there is a tax on idle capital, so that people who have large estates, for instance, find that it is necessary for them to sell off parcels of real estate to meet their obligations. There are a few exceptions to this generalization, as there are a few privileged classes in Norway.

The ship owners are in this class, but even here, you find that in order to avoid the oppressive taxes, Norwegian ship owners have resorted to foreign registries, Panama being one of their favorites, as they come under different rules and regulations by registering their boats in a foreign registry. It also has resulted in a flight of capital even to this country, where the tax burden is not

(Continued on page 74)

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NORWAY AND SWEDEN . . .

(Continued from page 73)

as great as it is over there. Many of the private ship owners have taken up citizenship elsewhere.

I believe the progressively steep taxation is having the reverse effect from that intended. The country certainly is losing a great deal of potential tax sources by the confiscatory taxes which are now in vogue.

Little Men in Big Jobs

However, the ship owners do have one advantage in that, for instance, new ship building can be depreciated at the rate of 25% a year from the moment the contract is let, and very often a new boat will be completely depreciated by the time the boat is ready for delivery and service. By the sale of such a depreciated vessel you can see there is some advantage to being a ship owner.

As far as building up the country's resources with the aid of foreign capital, this is almost an impossibility, as the Norwegian government has viewed with suspicion the inroads which developed years ago from the buying up of power rights by foreign capital. Consequently there is a law against any foreigner owning anything in Norway, so that foreign capital is practically unheard of in developing natural resources.

One senses very definitely that a socialized community, as in the Scandinavian countries, is an ideal one for bureaucrats. It is a veritable Eldorado, so that you find many small people in big jobs, and I might say that they seem to relish their positions of importance. The associated regimentation, of course, has its effect on the medical profession, which I will speak of in more detail.

Norway is rounding out its fortieth year of experience with the compulsory sickness and health insurance program, so the country has had great experience for over one generation in the practical application of this type of service. Most of the doctors in Norway consequently have never worked under any other system, so they have difficulty putting themselves in our position where we have had practically no experience in this type of activity.

In order to succeed professionally in Norway, one has to get into the procession from the start and stay there. Ultimately you will land on top by holding an important position as chief of one of their hospitals, which are state or municipally controlled.

Few Private Hospitals

The result of this system is that it is practically impossible to succeed in a private practice. First of all, a private practitioner with a few exceptions, has no hospital in which to practice. Staff admissions to hospitals are by government appointment, and consequently in communities where there are no private hospitals, one would have no opportunity whatsoever to follow his patient into a hospital. This situation is likewise true in Sweden.

RETIRE AT 65!

Next month Dr. Gundersen will tell how Norwegian and Swedish doctors are forced into retirement at 65.

Watch for this article.

In Sweden we learned that of a total of 58,000 hospital beds in the country, 54,000 are government beds. There are 4,800 physicians in Sweden, or 1 physician to every 1,500 inhabitants, and of these 4,800 doctors, 4,500 are employed in government positions, leaving only a balance of approximately 300 who are in private practice. In some of the larger cities, particularly Stockholm and Oslo, there are private hospitals which admit private practitioners.

The new government hospitals are very elaborately constructed. I was unable to get any definite figures as to the cost of hospital beds. The cost undoubtedly fluctuates because there has been a tide of increasing prices as there has in this country.

CIO Prods Membership on Compulsory Insurance

Chicago, Jan. 4.—The CIO, in its current publication, "Economic Outlook", urges a "comprehensive social insurance system which provides adequate security for the entire nation."

The union stated that state voluntary health insurance plans should be merged into one unified national system providing uniform benefits and universal coverage. The additional costs of these benefits would be borne by the employer, according to the union.

MISS TUMM

SMS Gets "Thanks" from Award Winner

Fall Creek, Wis., Dec. 16.—Lois Tumm, the outstanding 4–H Club member selected to receive the $100 achievement award of the State Medical Society for 1951, has expressed her thanks for the Society's recognition.

Miss Tumm, a Fall Creek club member, was able to attend the 30th National 4–H Club Congress as the result of the award. Each year the Society honors one 4–H club member who contributes notably to the health of his or her community and family through 4–H Club activities in the health field.

Miss Tumm wrote the Society:

"My trip to Congress was one which I shall always remember. It has inspired me to go back to my home community and work for the improvement of its health.

"We 4–H'ers realize the need for better health much more when we are backed by the State Medical Society."

U.W. Gets Grant from March of Dimes

Madison, Jan. 10.—The University of Wisconsin has just received an $8,110 grant from the National Foundation for Infantile Paralysis for investigations dealing with virus research.

The studies will be under the direction of Dr. A. F. Rasmussen, professor of medical microbiology and preventive medicine.

The grant is part of a total of $1,775,000 in March of Dimes funds being distributed among 23 medical schools, hospitals and research institutions in this country.

275 STATE MDs. MAY SEE MILITARY DUTY BY 1953

Madison, Jan. 10.—When hostilities broke out in Korea, the manpower pool of physicians in the United States numbered an estimated 203,000. Of this number, 7,600 physicians were on active military duty; another 32,000 reservists were potentially available, and more than 163,000 were not liable for military service.

Within a year this distribution changed drastically. Some 6,000 physicians began a 24-month tour of duty during the first year of the Korean action. Seven out of ten of these were recalled reservists, the others were registrants under Public Law 779, the "doctor-draft" law enacted in October 1951.

How Wisconsin Has Fared

About 88,400 physicians registered in the four priority groups set up by Public Law 779. This brings the total physicians potentially available for military service to more than 114,000.

Nationwide, Priorities I and II, the first groups to be called into service, account for some 13,000 physicians. Since registration, this number has been reduced by more than 2,000 who have gone on active duty.

Another 2,500 will probably never serve because they are physically unfit, sole surviving sons, or have a deferrable dependency status. This leaves about 8,500 men in Priorities I and II to answer military needs.

This group is held to be sufficient to provide replacements for the Army, Navy, and Air Force at least through 1952 unless the size of the armed forces is sharply increased.

Men in Priority III will probably not be called until sometime after January, 1953. Since Priority III will be called according to age, new graduates will form the bulk of those entering active service when the supply of men in the first two priorities is exhausted.

Those originally registered as Priority III in January 1951 will probably not be called in the next four or five years under the present authorized military strength. If current mobilization levels are continued it is reasonable to assume that Priority IV registrants will not be needed at all.

CURRENT STATUS OF WISCONSIN REGISTRANTS IN SELECTIVE SERVICE

Madison, Jan. 17.—The following is a summary of the status of Priority I and II registrants in Wisconsin as of January 17, 1952, as reported by State Selective Service:

PRIORITY I

Total number of registrants	230
Currently on active duty	57
Reservists subject to call at any time	52
Available, still being processed	18
Deferred as "Essential"	60
Deferred, dependency and "undue hardship"	3
Deferred, sole surviving son	1
Physically disqualified	39

PRIORITY II

Total number of registrants	45
Currently on active duty	5
Reservists subject to call at any time	4
Available, still being processed	14
Deferred as "Essential"	16
Deferred, dependency and "undue hardship"	3
Physically disqualified	3

How Wisconsin has fared as a result of the so-called "doctor-draft" is seen from the following summary and the table above. As of January 15, 1952, Wisconsin had 230 physicians in Priority I; 45 in Priority II; 641 in Priority III, and 866 in Priority IV.

Since the highest proportions of Priorities I and II are found in the graduating classes of 1947, 1948 and 1949, the resident and intern staffs of civilian hospitals were hit relatively hard. Resident services most affected have been medicine, obstetrics and gynecology and general practice.

Most physicians from the classes of 1950 and 1951 are in Priority IV—veterans with no ASTP or V–12 but with service as enlisted men. With the class of 1952 and later, the bulk of the graduates will have had no ASTP or V–12 training, and no military service, and will therefore be classified in Priority III. These will be eligible for duty on the basis of age.

More than three of every ten physicians in training in Wisconsin during the 1950–51 school year were in Priority I or II.

Nevertheless, most hospitals were able to get through the year without serious losses. Except in isolated cases, the hardship of withdrawals due to Public Law 779 has not been severe. This is chiefly due to the cooperation and understanding of local advisory committees, and the Department of Defense and the Selective Service System.

COURT SAYS INSURANCE COMPANY AND DOCTOR MAY BE SUED FOR SAME INJURY

Madison, Jan. 3.—The Wisconsin Supreme Court recently provided a decision which permits an injured plaintiff to bring separate suits against an insurance company and physician for the same injuries.

In the case at point (Greene v. Waters, Wis. 1951, 49 NW 2d 919) the plaintiff was injured in an automobile accident and claimed that her injuries were aggravated by subsequent medical treatment. She first settled with the insurance company, and in the release given that company, specifically reserved her cause of action against the physician. The physician contended that the plaintiff's release to the carrier also released him.

The court held that there could be a partial release, and permitted the plaintiff to proceed separately against the physician.

The net result of the court's decision is to make it possible for a plaintiff who recovers from an insurance company to sue the physician for the same injuries.

In event of liability on the part of the physician, it is doubtful, according to State Medical Society counsel, that the jury will take into consideration the amount of money earlier recovered from the insurance carriers. It is possible that the jury might award the plaintiff the full compensation for injuries suffered as a result of the accident itself, plus that for aggravation caused by the physician to the injuries.

LIVELY HEALTH COUNCIL MOVEMENT UNDER WAY IN STATE

Madison, Jan. 1.—The County Health Council idea is catching fire in Wisconsin.

Not only are an increasing number of county councils being established, but those already formulated are conducting vigorous programs in the fields of health education and improvement.

Gertrude M. Clouse, R.N., consultant in community organization for the State Board of Health, and Mrs. Otto Falk, Wauwatosa, secretary of the Wisconsin Public Health Council, point out that county health councils are voluntary organizations of civic-minded individuals who feel a desire to take an active part in the improvement of health in their communities. The county councils have no official status, but represent a potent force of local influence.

The Outagamie County Health Council exemplifies this definition. Under the guidance of its secretary, Mrs. Nelson Rodgers, Route 3, Appleton, the Council has been building a health improvement program around eight major health "needs" discovered in a 1950 health "census."

Education in mental health has occupied the council for some time. Now the group is engaged in a county-wide immunization education project involving a step-by-step plan to secure immunization of all Outagamie county children by their family physicians during their first year of life, and follow-up in the years to come.

Fight Brucellosis

The Dane County Association of Health Councils, with Mrs. Elmer Crandall, Edgerton, as secretary, is continuing a county-wide diabetic survey into 1952. More than 200 representatives of 27 local councils attended the county council's annual meeting last October, revealing unusual interest in the movement.

Miss R. Elizabeth Sapp, R.N., Green Bay, secretary of the Brown County Welfare Council, reports that it is working diligently for the selection of a physician with proper qualifications as health commissioner for the city of Green Bay.

HEALTH COUNCILS flourish on active participation of interested citizens. Planning local health programs with local people and finances is their major function.

The Polk County Public Health Council is one of the most active in the state. Miss May Bryne, Balsam Lake, secretary, reports three major projects of current interest. Fluoridation of every public water supply in Polk county is sought. To date, Amery, Osceola and Balsam Lake have plans to install fluoridation equipment.

Last spring the Council conducted a "readiness for school" campaign to check the health of youngsters entering school. A repeat program, based on the success of the 1951 campaign, is planned for this coming spring.

That the Polk County Council means business is evident from its actions in the nursing field. The Council and other health authorities agreed that one public health nurse could not adequately serve Polk county. The Council allotted $3,600 for the first year's salary of a second nurse, and agreed to pay all her expenses.

A continuous well-planned program of mental health education is producing county-wide results for the Ozaukee County Health Council. Mrs. Wm. Foy, Thiensville, secretary, reports that talks, slides, skits and pamphlets have been used to reach many segments of the public.

Brucellosis eradication and control is getting full attention of the Barron County Public Health Council in which Miss Inez Halsted, Barron, is secretary. The Health Council is about to become the Health Division of the Barron County Community Council.

In every area where they have been established, health councils have made a good name for themselves by assuming responsibility for aggressive programs for the improvement of local health conditions.

Health councils have the endorsement and active support of the State Medical Society. Most local councils count physicians among their membership to serve in an advisory capacity. Dentists, veterinarians and osteopaths are also prominent in many councils.

Illinois Cracks Down on Unlicensed Chiropractors

Springfield, Ill., Dec. 7.—Wisconsin's southern neighbor has begun a state-wide crackdown on unlicensed medical practitioners, most of them chiropractors, according to C. Hobart Engle, director of the state department of registration and education in Illinois.

Immediate results were six convictions and cases are pending against 73 others. The department believes there are more than 400 unlicensed chiropractors in Illinois.

Fines have ranged up to $800 and costs, and at least one jail term was meted out.

Department files reveal cases in which unlicensed practitioners have caused death by faulty manipulations resulting in vertebrae fractures. In one case a diabetic was advised to quit insulin and later died.

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« « « EDITORIAL » » »

The Blue Books in Review

In 1927 and 1928 the State Medical Society published a small book containing a summary of the more important laws pertaining to the medical profession of the state of Wisconsin. The booklet was to be the first of an annual series, known as the Medical Blue Books. The 1928 edition was revised and enlarged in 1929, but because of the subsequent depression years the Blue Books were discontinued for a period of time.

The first two editions made it apparent that a more detailed survey would be both valuable and desirable. Consequently, for several years prior to 1939 the type on various pertinent articles which were published in the *Wisconsin Medical Journal* was saved for future use. Plans were made to develop what ultimately became an annual edition of the Journal, known as the *Medical Blue Book*. The December 1939 issue of the Journal was the first of ten annual Blue Book issues. Each year the previous edition was brought up-to-date and new topics of interest were added.

In January 1949, some of the articles of the previous Blue Books were incorporated into the *Wisconsin Medical Blue Book*, which was issued by the Society as a semi-permanent publication intended as a reference on a wide variety of subjects. The articles were of a nature which did not require annual revision.

The January 1949 and all subsequent January editions of the Journal have been issued as supplements to this permanent Blue Book. In this way an up-to-date record of laws and regulations affecting the medical profession in Wisconsin was made readily available to Wisconsin physicians. In addition, it is planned to revise and republish the *Wisconsin Medical Blue Book*, itself, approximately every five years.

The Blue Books are devoted to medicolegal problems of particular interest to the practicing physician and to the official material of the State Medical Society and the American Medical Association. The assistance of various state departments, as well as the assistance of the legal counsel of the Society, is enlisted in compiling many of the articles. Legislators and others in an official capacity in the State are frequently given reprints from the Blue Books of articles which apply to their special fields. Also, the permanent Blue Book is sent to all new members of the Society, and to the junior medical students at both state medical schools.

Both the Blue Book and the January supplements are punched in order that they may be kept together in a single ring book for handy reference. To assist subscribers with the assembling of this material under one cover, a ring book, embossed with the words "Wisconsin Medical Blue Book" on the front and back, can be purchased from the State Medical Society of Wisconsin for one dollar.

The Student Loan Fund

ESTABLISHMENT of the Student Loan Fund of the State Medical Society creates an unusual opportunity for physicians to apply the principles of the Hippocratic Oath by helping youthful aspirants to the profession of medicine achieve their goal. It is reported that "at least half" of the 600 medical students in the two Wisconsin medical schools could use some financial help. About one-third are said to need complete support. With medical education now requiring more and more devotion to studies, and with the yearly cost of such education ranging from $1,200 to $1,750, the Student Loan Fund promises to fulfill a great need.

The Student Loan Fund grew out of a proposal by Dr. H. H. Christofferson, Colby, at his inauguration as president of the State Medical Society in October, 1950. The fund was organized in August, 1951, at the initial meeting of its Board of Trustees. Their goal is the accumulation of a $250,000 fund to provide assistance to needy and deserving medical students.

The fund is a trust administered by a board of seven trustees. Four trustees are the president, president-elect, chairman of the Council and secretary of the State Medical Society who serve as trustees during their terms of office as such officers of the society. These trustees select three additional trustees, one of whom must be a physician.

Present board members are: A. H. Heidner, M.D., West Bend, chairman; the Honorable A. Matt Werner, Sheboygan, vice-chairman; C. H. Crownhart, Madison, secretary-treasurer; Ira R. Sisk, M.D., Madison; R. G. Arveson, M.D., Frederic; J. C. Griffith, M.D., Milwaukee; and the Honorable Oscar A. Rennebohm, Madison.

The fund will be used to provide assistance in the form of loans, with preference given to students enrolled in the University of Wisconsin Medical School or Marquette University School of Medicine.

Who is Eligible

Residents of the State of Wisconsin who are presently enrolled, or about to enroll in a class "A" medical school, are considered eligible to apply for a loan. The Board may also grant loans to residents of the state who have received their M.D. degree and are fulfilling the requirements of an internship. Neither pre-medical students nor residents are eligible for loans at this time.

The applicant must demonstrate to the Board's satisfaction that he is in need of financial help, and that such financial help is essential to his medical education.

Applications for student loans must be made directly to the Board of Trustees of the Student Loan Fund.

Loan Limits and Security

A loan may be made in any amount not to exceed $1,000. The applicant may apply as many times as he sees fit, and may obtain more than one loan so long as the total obligation does not exceed $3,000. Loan money will be advanced to the borrower as needed, within the maximum.

Loans are to be repaid within three years of the time the student receives the degree of Doctor of Medicine. If the student severs himself from his medical education prior to receiving the degree, the Board may require repayment at an earlier date.

Any interest on the loan is waived until the borrower has received the M.D. degree, or until he has disassociated himself from a medical school, voluntarily or otherwise. The Board may, at its discretion, suspend interest charges until the applicant has completed his internship. The Board is also empowered to suspend interest or extend the maturity date of the loan to fit special circumstances. In no case may interest charges exceed 4 per cent per year. The following interest charges may be applied:

1. Two per cent if paid before completion of internship.
2. Three per cent if paid within two years of receipt of M.D. degree.
3. Four per cent if paid after two years from receipt of M.D. degree.

Applicants for loans are subject to interview by members of the Board of Trustees. The Board must make annual reports to the Council of the State Medical Society and will make other reports at its discretion.

Loans to medical students will be made as soon as contributions to the fund total $20,000. Physicians are urged to make contributions or bequests to the fund. Checks should be made payable to THE STUDENT LOAN FUND, STATE MEDICAL SOCIETY OF WISCONSIN, 704 E. Gorham Street, Madison 3, Wisconsin. Contributions are deductible in computing taxable net income.

Any person desiring to leave a portion of his estate for the perpetuation of the fund is urged to designate the bequest according to the following form:

> "I hereby give, devise and bequeath to the Student Loan Fund of the State Medical Society of Wisconsin, 704 E. Gorham St., Madison 3, Wisconsin, the sum of _____ dollars to be used for the objects and purposes of the Fund."

Every contribution to the fund will be gratefully appreciated. Inquiries or other evidences of interest in the fund may be directed to the State Medical Society or the Board of Trustees at any time.

Donations and Bequests For Research

IN HIS capacity as a counselor, the physician is often called upon to advise patients who wish to make gifts, donations, or bequests for the purpose of furthering progress in the prevention, control, and treatment of disease. Many physicians themselves wish to contribute to worthy projects in the furtherance of their profession and the medical arts and sciences. With most, this desire is prompted by personal experience or acquaintance with a particular disease or infirmity. Often, their desire to give is accompanied by inadequate knowledge of the means by which their intentions can be carried out.

Almost all charitable, scientific, and educational organizations are empowered by their articles of incorporation or their constitution and by-laws to accept gifts, devises, and bequests of money and property, both real and personal, and to manage and administer such money and property in manners adapted to the proper promotion of the purposes of the donor and the organization. This article is accompanied by a tabulation of the major health and scientific organizations and by the conditions under which they are willing to accept donations or bequests of any kind.

Unless restrictions are placed on their use, donations or bequests made to such an organization will be used for the general furtherance of the objectives and purposes of the organization as outlined in its articles of incorporation.

Persons wishing to assure the use of their donations for specific purposes must describe their intentions in writing at the time the donation is made. It is advisable to communicate directly with the organization to which such a donation is contemplated. The average organization is empowered to accept funds earmarked for specific purposes so long as the purposes fall within the scope of its charter. The board of trustees or a research committee usually evaluates all special requests to determine whether the proposed donation can be used for the purposes intended. Most organizations are very helpful in advising the donor how his contribution may be tailored to the purposes of the organization while carrying out his wishes. Some will make available to contributors a list of approved research projects that await financing.

Direct Donations

When a contribution is made as a gift during the lifetime of the donor, it is customary for the donor to transmit the gift with a letter to the governing body of the organization, such as the board of directors, indicating the manner in which the funds are to be used and such other terms and conditions as might be appropriate. When the contribution is a large one, it is well to discuss the proposal with officials of the organization in advance.

Bequests

If the contribution is to be made by a bequest set forth in a will, it is necessary to specify the title of the organization, and the purpose for which the contribution is to be used. The terms of the bequest may specify that the fund be used for "Research," in which case the organization would determine the particular field of research for which the donation would be used. If the bequest is to be used for research in a specific field or in the causes and cures of a particular disease, the terms should so specify.

The terms of the bequest should also provide whether the entire principal of the bequest, only the income earned on the principal, or both, should be used for the purposes indicated. It is suggested that bequests take the following standard form:

> "I give and bequeath to _____(name)_____, a corporation created under the laws of the State of _____, and located in _____, the sum of ($_____) Dollars, to be used in the furtherance of its objects and purposes."

When the donor wishes to earmark the bequest for particular purposes, the final phrase of the above statement may be reworded to express the intent of the donor.

Memorial Contributions

Every organization accepting contributions offers the opportunity to memorialize the name of the donor or any other designated person in perpetuity. For example, if the bequest is given as a "living memorial" to a certain individual, the terms of the will should specify the name of the fund, such as the "John Doe Fund for Medical Research."

Most organizations employ appropriate procedures for acknowledging contributions according to the wishes of the donor. Families or friends of the person being memorialized may be notified of the establishment of the fund. Donors desiring this type of service are requested to supply the names of those to be notified.

Tax Exemption

Section 72.79 of the Wisconsin Statutes states in effect that all transfers of property (defined as both real and personal) to or for the use of any community chest fund, foundation or association *organized and operated exclusively for religious, charitable, scientific or education purposes* shall be exempt from a gift tax. The 1951 session of the legislature further provided that when other states provide for a similar tax exemption, reciprocity will be granted. It is well to point out, however, that the laws relating to taxation are subject to change at any time and the donor of any substantial gift should consult an attorney for the current law on tax exemptions.

Organization	*Procedure for Making Donation or Bequest*
American Cancer Society 47 Beaver Street, New York 4, New York	*Donations* to the national organization are divided—60 per cent to the state of origin, 25 per cent to the national research program and 15 per cent for the operation of the national office. *Bequests* to the national organization will be used completely by national for purposes outlined in the charter, unless specifically requested for some other purpose.
Wisconsin Division, American Cancer Society 652 East Gorham Street, Madison, Wisconsin	*Donations*—Same as above. *Bequests*, made to the Wisconsin Division, will be used 100 per cent for whatever purposes specified.
American Dental Association 222 East Superior Street, Chicago 11, Illinois	Accepts general and specific donations, particularly for the advancement of dental research.
Wisconsin State Dental Society 1233 Bankers Building, Milwaukee 2, Wisconsin	Same as American Dental Association.
American Diabetes Association 11 West 42nd Street, New York 36, New York	Accepts general or specific donations for dissemination of information, health education and case finding, and research. Please contact Association before making earmarked contributions.
American Hearing Society 817 Fourteenth Street, N.W., Washington 5, D.C.	The objectives of this organization are prevention of deafness, conservation of hearing and rehabilitation of the hard of hearing. It accepts donations for research, education or direct services through local affiliates to be used for general or specific purposes consistent with the above named objectives.
American Heart Association 1775 Broadway, New York 19, New York	Donations and bequests welcome. They are divided 25 per cent to the American Heart Association, Inc. unless the donor specifies differently. Half of the 25 per cent share is earmarked for research, and the remainder for national education and development of state associations. The 75 per cent share is budgeted to research in Wisconsin in the field of diseases of the heart and blood vessels; medical and nursing education; public education in prevention; and community service to cardiac patients.
Wisconsin Heart Association 425 East Wisconsin Avenue, Milwaukee 2, Wisconsin	Same as the American Heart Association.
American Medical Association 535 North Dearborn Street, Chicago 10, Illinois	Will consider donations or bequests made to it for general or specific purposes including research. Acceptance by Board of Trustees depends on conditions incident to the bequest.
State Medical Society of Wisconsin 704 East Gorham Street, Madison, Wisconsin	Members or others who contemplate donations or bequests to the State Medical Society for general or specific purposes are requested to contact the Secretary.
American Medical Education Foundation 535 North Dearborn Street, Chicago 10, Illinois	Contributions or bequests made to this AMA–sponsored Foundation are entirely devoted to support of medical education. Any gift may be earmarked for any one of the 79 approved medical schools in the nation.
American National Red Cross 17 & "D" Street, N.W., Washington, D.C.	The corporation may receive gifts, bequests, devises, legacies, and donations for such purposes as are within the general scope of its corporate purposes and powers, and upon such acceptance shall expend and administer such contributions for the purposes specified. Unless the local chapter is specified as the beneficiary, funds derived from gifts made by will, trust, or similar instrument, go to the national organization.
American Pharmaceutical Association 2215 Constitution Avenue, Washington 7, D.C.	Accepts donations or bequests for general or specific use. Suggest query before making earmarked contribution.
Wisconsin Pharmaceutical Association 161 W. Wisconsin Avenue, Milwaukee 3, Wisconsin	Same as American Pharmaceutical Association.
American Public Health Association 1790 Broadway, New York 19, New York	Funds earmarked for specific research accepted if the proposal is within the program and objectives of the Association. Communications are welcome.

Organization	*Procedure for Making Donation or Bequest*
American Social Hygiene Association 1790 Broadway, New York 19, New York	Accepts any kind of donation or bequest, including those for such specific research in the field of venereal disease control as it is "in a position to carry out with competence."
Arthritis and Rheumatism Foundation 535 Fifth Avenue, New York 17, New York	Accepts donations and bequests for general or specific research in the rheumatic diseases; improvement of community treatment facilities, and other stated objectives for control of arthritis and rheumatism. Earmarked donations and bequests are acceptable if designated purposes are in line with Foundation policies and program. With earmarked donation, send explanatory letter. For bequest, use a standard statement.
Wisconsin Arthritis and Rheumatism Foundation 208 East Wisconsin Avenue, Milwaukee, Wisconsin	Accepts general or specific donations. Contact association before making earmarked contributions.
Marquette University School of Dentistry 604 North 16th Street, Milwaukee, Wisconsin	Accepts donations for dental education and research. If a specific type of research is requested under a bequest, the Dental School will reserve the right to decide whether the fund and the research under it is appropriate before accepting the fund. Donations are to be made to the "Marquette University School of Dentistry."
Marquette University School of Medicine 561 North Fifteenth Street, Milwaukee 3, Wisconsin	Accepts donations for medical education and research. Donations are to be made to the "Marquette University School of Medicine."
National Association for Mental Health, Inc. 1790 Broadway, New York 19, New York	Accepts any funds for its program to promote the cause of mental health. Any contribution earmarked for specific research is subject to the approval of the Professional Committee of the National Association.
Wisconsin Association for Mental Health 405 East Grand Avenue, Beloit, Wisconsin	Accepts funds for the promotion and conservation of mental health, including those earmarked for specific research and educational activities. All program activities subject to approval of Board of Directors.
National Epilepsy League, Inc. 130 North Wells Street, Chicago 6, Illinois	Accepts contributions for specific research in the causes and treatment of epilepsy. Funds may be earmarked for educational and clinic use as well as for pure and applied research. Donations may be made to national organization or its affiliated state groups. Request use of standard statement on bequests.
National Foundation for Infantile Paralysis 120 Broadway, New York 5, New York	Accepts any contributions or bequests. If the contribution is made through a county chapter, one half will be used for local service, the other half will be sent to the National Foundation for research. If the donor wishes the entire donation to be used for research, the donation must be accompanied by a statement to that effect.
National Fund for Medical Education 475 Fifth Avenue, New York 17, New York	Accepts contributions or bequests to be used in support of medical education. Acts as distributing agency for all funds collected for aid to medical schools, including contributions to the American Medical Education Foundation.
National Multiple Sclerosis Society 270 Park Avenue, Suite 7G, New York 17, New York	Accepts any contributions or bequests for use in program of combating Multiple Sclerosis. *Earmarked Gifts* are used as indicated by the donor, providing the project meets with the approval of the Medical Advisory Board and the Board of Directors. *Unearmarked Gifts* will be used for general program and divided with the local chapter on a 60–40 basis, 60 per cent for the chapter and 40 per cent for the National Society. Interested donors may write the Society for information concerning the current research program and the approved proposed projects.

Organization	*Procedure for Making Donation or Bequest*
National Research Council 2101 Constitution Avenue, Washington 25, D.C.	Accepts donations for fundamental and clinical research in a score of fields in the medical sciences. Donations may be earmarked for a particular project. Write Business Manager specifying amount that is desired to be contributed and purposes for which a contribution is to be made.
National Safety Council 425 North Michigan Avenue, Chicago 11, Illinois	Accepts donations or bequests for general use or specific research and program projects in harmony with objective of reducing deaths and injuries due to accidents.
National Society for Crippled Children and Adults 11 South LaSalle Street, Chicago, Illinois	Accepts donations or bequests for education, direct service, or research. Will use funds for these three purposes unless otherwise specified. Donor may specify that fund be used for specific purposes by the Wisconsin Association for the Disabled.
Wisconsin Association for the Disabled 119 East Washington Avenue, Madison 3, Wisconsin	Accepts donations for research, education, and direct services for crippled children and adults. Requests donor to contact Association when wishing to designate funds for a particular purpose.
National Society for the Prevention of Blindness 1790 Broadway, New York 19, New York	Accepts funds or donations for specific research when requested. Unrestricted donations may be used for medical research, preventive services, and education of lay and professional persons. In making bequests, use of standard statement is requested.
National Tuberculosis Association 1790 Broadway, New York 19, New York	Accepts any donations or bequests, but prefers they be given for general research purposes.
Wisconsin Anti-Tuberculosis Association 1018 N. Jefferson Street, Milwaukee 2, Wisconsin	Accepts donations and bequests for general or specific use in furthering the purposes of the association in the fields of education and demonstration for the eradication of tuberculosis and the rehabilitation of tuberculous persons.
Sister Elizabeth Kenny Foundation 2400 Foshay Tower, Minneapolis 2, Minnesota	Accepts contributions or bequests to finance varied program in field of polio. Funds contributed finance clinical research; provide scholarships to trained registered nurses and physical therapists to become Kenny Therapists; provide the Kenny treatment at no charge to polio victims; finance treatment centers; conduct medical seminars; and provide public information relative to the Kenny concept and treatment of polio.
Student Loan Fund of the State Medical Society 704 East Gorham Street, Madison, Wisconsin	Accepts donations or bequests to assist worthy and deserving medical students in attaining their professional education. Funds will be used at the direction of the Board of Trustees. Address donations to the Board.
United Cerebral Palsy Associations, Inc. 50 West 57th Street, New York 19, New York	Accepts donations for general or specific use in the care, treatment, and rehabilitation of the cerebral palsied and for research in cerebral palsy. Local United Cerebral Palsy affiliates exist in many communities and accept donations under the same conditions.
University of Wisconsin Medical School 418 North Randall Street, Madison 6, Wisconsin	Accepts funds or donations for general or specific research. Assures exact stewardship for any research program in areas where it is qualified to serve. Bequests should be made in standard statement to "The Regents of the University of Wisconsin" or "The University of Wisconsin Medical School" and specify the terms under which the bequest should be used.
Wisconsin Alumni Research Foundation P.O. Box 2059, Madison 1, Wisconsin	Donated funds are usually incorporated in the general investment portfolio of the Foundation. All grants for research are made through the University of Wisconsin Research Committee. Distribution of yearly grants is at the discretion of this committee except for earmarked funds which carry with them specific directives when allocated to the committee. Address donations to the Board of Trustees

Medical Partnerships

Introduction

WHEN two or more physicians decide to be associated with one another, such association takes one of three forms. Under one form, one of the physicians, usually the older, employs one or more other physicians on a salary, or a combined salary and bonus basis. A second form of association is one under which two or more physicians share the reception room and laboratory facilities, as well as clerical staffs, on an agreed basis, but each retains the full earnings of his professional practice. The third, and most intimate form of professional association, is the partnership. Under such an arrangement, two or more physicians agree to share the profits and losses and the other ups and downs of their pooled professional efforts.

Practice in the form of a corporation has been excluded from consideration here because of the well established legal principle that a corporation cannot practice medicine. Accordingly, a corporate organization in the medical field usually is limited to the ownership of land, building, and equipment which may be leased or otherwise made available to two or more physicians. Those complications represent a separate subject which does not properly fall within the scope of this article.

Nature of Partnership; Some Disadvantages

A partnership is one of the closest forms of personal and legal association which exists. On the legal side, inasmuch as each partner is held by law to be an agent of the partnership, he may bind the partnership by his actions, which is another way of saying that he may bind all other partners. That is especially true of a state like Wisconsin, which does not regard the partnership as possessing legal entity or personality, such as characterizes a corporation. The law of this state regards a partnership as nothing more than an aggregation of two or more persons. Such action by one partner may be nothing more than the decision to subscribe to a magazine or to purchase a new piece of equipment. In another situation it may also involve his partners in alleged liability for negligence in the treatment of a patient.

Further, the partnership assets are subject to the rights of the creditors of each partner for obligations incurred by that partner in the conduct of partnership's activities. Such creditors, having established their rights, may proceed against the full partnership assets should that be necessary to satisfy such rights.

Clearly, there are substantial professional personal and financial risks implicit in the partnership relationship.

Some Advantages of a Partnership

One of the principal advantages of a partnership is that it permits the pooling of professional skills, of separate backgrounds, and of the power of different types of men to attract patients. In the practical financial aspect, a partnership permits the pooling of capital. It also serves as a cushion against losses to have one or more persons share those losses. Where all but the owner of a practice are on a salary basis, such owner has to carry losses alone.

A further marked advantage of a partnership arrangement is the relatively greater stability of professional practice which this type of association makes possible. Not only is consultation likely to be freer while all partners are there, but there is greater likelihood of continuity when a partner is absent for any cause, or when he retires or dies. This factor of continuity is advantageous alike to the patient and physician. A partnership can build its practice at certain standards with greater assurance than is probably possible in other types of association, that such standards will be continued during the absence or following the withdrawal or death of one or more partners.

On the economic side, disposition of a practice can be more flexibly arranged through a partnership than through other means. The conclusion seems warranted that the reasonably assured advantages of a partnership substantially outweigh its potential disadvantages.

Establishment of a Partnership

A partnership may in fact exist by consent and understanding between the partners, even though the fact is not known to the general public. It may also exist by oral understanding, or by operation of law, even where there is no formal agreement. The first arrangement might have possible ethical considerations. The second type is clearly imprudent on tax and other financial grounds. Every partnership between professional men for the open practice of their profession on an association basis should be openly and publicly declared. Further, every such association should, for the protection of the parties during life, and for the protection of their estates and families on death, be formalized in a written contract.

Advantages of a Written Partnership Agreement

It is entirely possible for two reasonable individuals who are dealing with each other on a verbal basis to misunderstand each other. No contract can be written which will cover all situations, or

remove all such possibilities. Areas of potential misunderstanding can be greatly reduced, however, when the intention of the parties on basic matters is put in writing. Such questions as name and the right of its continuing use; the inclusion or exclusion of such intangible factors as good will; the valuation of tangible assets and of accounts receivable, either of which may vary substantially from those shown on the partnership books; the share of each partner in the capital of the partnership; the share of each partner in the gains or losses of the partnership, which again, may vary substantially from his capital investment, all these, and many other points may be covered, and are ordinarily settled by a competently drafted partnership agreement.

Termination of Partnership

Ordinarily, a partnership between physicians is dissolved on the withdrawal or death of any of the partners. A partnership agreement may provide, however, for the continuation of a partnership in either contingency. Thus, the retired partner may continue to enjoy the fruits of his efforts on at least a limited basis during the period required for collecting his accounts and winding up his interest.

In like manner, the widow and children of a deceased partner may, through contract made while the physician was alive, avoid the disadvantage of a forced liquidation. This ordinarily will permit a greater total payment to the retired physician, or to the heirs of a deceased physician, than is possible from an immediate sale or other liquidation of his interest. It also permits a substantial tax saving to the surviving partners under the present provisions of the federal income tax law.

The tax advantage above mentioned has a rather technical basis which can be summarized with substantial accuracy as follows: Where a partnership agreement makes no provision for the sale of the interest of a retired or deceased partner, the purchase of such interest by the remaining partners is not deductible by them for income tax purposes, but has to be capitalized. Only those portions of such capital investment as are depreciable can be written off during the useful life of such assets.

On the other hand, where an inactive or deceased partner has a continuing participation in the net income of a partnership for an agreed period, such income is reportable and taxable as to him or his heirs as ordinary income, rather than as capital gain or loss. All such payments are *deductible* from the net partnership income of the remaining active partners. Generally speaking, the inactive partner or his heirs suffer no substantial tax disadvantage under such an arrangement; whereas, the living partners enjoy a substantial tax advantage by reason of which they can pay more for such interest than would otherwise be the case.

Basic Provisions of a Partnership Agreement

Following is a list of basic provisions which should be carefully worked out and inserted in a partnership agreement. Accompanying them are brief comments either to indicate the importance of the provision, or advice as to its phrasing.

1. *Name and Purpose.*—The name should be chosen carefully, and will frequently bear the names of two or three partners (seldom more), or of the community. If the name of one or more partners is used to designate the professional firm, the contract should provide whether the right to continued use of such name is to survive the retirement or death of such partner.

2. *Location.*—The locality in which the partnership proposes to practice should be set out specifically. If the partners conclude that they wish to insert into the contract a covenant limiting the right of a withdrawing partner to engage in practice within a particular area for a particular time, this should be done carefully in the body of the agreement. It is also necessary that the area limited and the time provided in such case be reasonable under all the circumstances.

3. *Duties of Partners.*—The agreement should set out with care whether the partners are to give full or part time to the affairs of the partnership, and to provide any limitations on possibly conflicting other professional activities, or on non-professional activities.

4. *Managing Partner.*—It is frequently advisable to designate a managing partner. This centralizes authority for purchasing, for making financial decisions, and for establishing essential supervision over nursing, technical and clerical staffs. It may be desirable to rotate the management so as to give all partners such experience over a period of time.

5. *Initial Valuation of Partnership Assets.*—It is important that the agreement designate carefully just what assets are included in the initial capitalization of the partnership. Such tangible assets as professional library, equipment, and cars, are relatively easy to evaluate. Such intangible assets as outstanding accounts and notes receivable are likewise fairly easy to evaluate. The difficulty arises when one seeks to place a monetary valuation on such intangible assets as an established professional name, the right to continue the use of that name, the value of an established practice, the value of an advantageous long-term lease, and the like.

6. *Capital Investment.*—The agreement should set out carefully the percentage of interest of each partner and the amount of capital to be paid by him; also which interests have been paid for, or partially so. Any partnership interest not wholly paid for should be the subject of carefully worked out business arrangements. The most common of these is the giving of a note without interest, or at a low rate, to be paid the lending partner or partners by the borrowing partner out of the latter's annual share of net partnership profits.

7. *Sharing and Definition of Expenses.*—While it might seem too obvious to insert, it has been found good practice for the contract to make it clear that all partners agree that expenses shall have the first claim on partnership gross earnings, also what items are to constitute such expenses.

8. *Sharing of Profits or Losses.*—The share of each partner in the net profits and losses of the firm should also be set out with care. This may, but need not be the same percentage as the interest of each partner in the capital structure. A younger physician, for example, might have the same financial investment in a medical partnership as an older partner, but be less productive of professional income. Ordinarily, the younger partner would not have the same drawing power. Such differences can be reflected by agreement as to the extent of participation of each partner in the net profits or losses of the firm. As a matter of law, the sharing of profits or losses is perhaps the most fundamental single test in determining whether a given association is a partnership or something else.

9. *Partnership Drawings.*—The actual financial outcome of a partnership year obviously cannot be determined until the year has ended and the books have been closed. The usual practice is to establish drawings for each partner which resemble salaries, but which are *not* deductible for income tax purposes as salaries are. The reason for the difference in treatment is that salary is an expense, but it is recognizable only where an employer–employee relationship exists. Partners are considered in tax law as associated self-employed persons who are not allowed to deduct as expenses what they earn and pay themselves. It is a prudent practice to establish aggregate drawings at not over 85 to 90 per cent of estimated net income. This allows the partnership to maintain a desirable working capital and to establish some savings for year end distribution or for periods when one or more partners is ill.

10. *Distributed vs. Distributable Shares.*—The problem in this field may be best illustrated by example. Assume that the share of Doctor X in the net cash income of a medical partnership for a particular year was $20,000. Assume during that year he had drawn $1,500 a month, or a total of $18,000. The latter figure of $18,000 is the *distributed* share, namely, what he actually got. The figure of $20,000 was his *distributive* share, or the one to which he was entitled on a bookkeeping distribution of the net earnings when the books for the year were closed.

Doctor X can draw or retain in the firm the $2,000 as soon as it has been determined that he is entitled to that extra amount as the balance of his share of profits for the year. He must, in any event, report that higher figure for *both* federal and state income tax purposes, whether he draws it out of the firm or leaves it there.

Conversely, if Doctor Y of the same firm drew $1,000 a month during the year, or a total of $12,000, and his *distributive* or earned share was found at the end of the year to be only $10,000, he would owe the firm the sum of $2,000. This is the excess of the *distributed* or estimated advance payment to him over what was ultimately determined to be his true or *distributive* share. He would report for income tax purposes not the $12,000 which he drew through erroneous estimate, but the $10,000 to which he was entitled by the terms of the partnership contract.

This point should be covered in the agreement.

11. *Vacation and Postgraduate Study.*—It is advisable to establish by formula the period of vacation of each partner. It is common to do this on a basis of the length of time a partner has been a member of a particular firm, or a predecessor firm in the same community. Agreed vacations are known to vary from a minimum of two weeks to as much as three months in this state.

In like manner, it may be advisable to provide by contract for the allowance of time needed for postgraduate studies, or for participation in affairs of professional medical organizations, should it be anticipated that one or more partners will desire or require a substantial amount of time for such purposes.

12. *Illness of Partner.*—On this important subject, four points may be emphasized. The first is that a medical partnership is generally collecting past due accounts. Thus, the financial impact caused by the sustained illness of a partner is not felt at once. Second, there is a difference between partial and total incapacity. Third, there is a great difference between temporary and permanent disability, whether partial or total. It is well for a partnership agreement to provide the financial arrangements which are to control during the illness of a partner. Any such arrangements should take any of the three above factors into account.

A fourth factor is the amount of disability or time loss insurance which the partnership may carry for each of its members, or which the members may carry as items of personal expense. The premiums of such policies are not deductible for income tax purposes; neither are payments to physicians under such policies includable in gross income.

Following are typical arrangements made to cover the illness of a physician partner:

(*a*) If the illness or incapacity is partial, and does not extend beyond six months, no reduction is made in drawings.

(*b*) If such partial incapacity continues beyond six months, an adjustment in such partner's financial participation in the firm is to be negotiated which will recognize the extent to which he can practice his profession.

(*c*) If the illness or incapacity is total, maintain established drawings of such partner in full up to six month maximum.

(*d*) If such total incapacity continues beyond six months, reduce such financial participation by degrees, so that after 18 months, for example, the remaining partners could dissolve the firm, or make other arrangements suitable to them. Established

drawings of such a partner might also be reduced after six months by the amount of his payments under disability or time loss insurance, up to an agreed figure or percentage.

13. *Withdrawal, Retirement, or Death of a Partner.*—Of all the problems faced by a partnership, there are probably none which are more difficult to evaluate and to solve by contract than the related problems of withdrawal, retirement, or death. As used in this connection, "withdrawal" means the optional leaving of a partnership, irrespective of cause other than health. "Retirement" is limited to the leaving of a partnership on grounds of health.

On consideration, it would seem rather evident that where a partner is withdrawing from a firm because the other partners wish it or because he desires to practice elsewhere, there are elements of dealing at arm's length and of individual judgment and volition which are lacking in the other two situations. Further, there is a far greater element of individual judgment and of negotiation possible upon retirement for health reasons than there is with an estate or heirs following death.

Some medical partnerships are beginning to reflect some of the above factors in the financial settlements made where a partner leaves a firm. Ordinarily, the settlement will be smallest where a partned *withdraws;* it will be more generous where a partner *retires* for reasons of health; it will be most generous where a partner *dies* without having withdrawn or retired. The legal and tax considerations of such arrangements call for careful draftsmanship if the wishes of a partner and the maximum advantages of such arrangements are to be assured.

14. *Insurance.*—The partnership agreement should consider at least two types of insurance. The first is what insurance is to be carried by individual partners. This would ordinarily include individual malpractice and car insurance.The minimum limits of such policies should be set out in the agreement, or left in the discretion of the managing partner. It may also include minimum amounts of disability or time loss insurance.

The second type of insurance is that to be carried by the partnership, generally as an expense. This would include public liability on the premises of the partnership; partnership malpractice insurance covering the potential liability of all partners for the professional acts of any one of them; workmen's compensation and employer's liability; fire and extended coverage on equipment and library of the partnership; rental or similar insurance to cover special expenses in connection with loss due to fire or other casualty, non-ownership automobile and hired car insurance; comprehensive coverage on the cash and securities of the partnership, including wrongful loss or mysterious disappearance.

If the partnership concludes to carry disability or time loss insurance on its partners, this can be handled by the partnership as a matter of convenience, but it should be charged to the individual drawing accounts of the partners, since such premiums are not deductible for income tax purposes. The same holds true for the same reason, among others, of life insurance, which is discussed in the next paragraph.

A third class of coverage, although not treated in the partnership agreement, is life insurance, which the partners carry on the lives of each other. Thus, if Doctors X, Y, and Z were partners, and each of them was insurable, it is a common practice to provide by a *separate* contract, wholly independent of the partnership agreement that Doctors Y and Z will insure the life of Doctor X and pay the premium thereof in agreed ratios, and that Doctors X and Z will do the same for Y, and Doctors X and Y will do the same for Doctor Z.

The above arrangement can also be handled through a trust agreement, although this is needlessly cumbersome and costly unless a large insurance program is involved. While premiums on such policies are not deductible as expense, the receipt of insurance proceeds by the surviving doctors is not taxable as income. Neither are such insurance proceeds taxable to the estate of the deceased doctor where he did not own or control the policy.

15. *Professional Records.*—It is well for a partnership agreement to provide what disposition is to be made of case histories and other professional records in the event of retirement, withdrawal or death of a partner, or dissolution of the partnership.

16. *Dissolution.*—If an agreement is silent as to dissolution of a partnership, the Wisconsin statutes control. Where special arrangements are preferred by partners, it is believed desirable that this subject be spelled out in the partnership agreement.

Conclusion

Few personal or professional decisions are more important in the life of a practicing physician than that of entering into a partnership. It is necessarily an intimate relation at professional, financial, and personal levels. It should not be entered into lightly, or with undue haste. Each partner should know the professional qualifications, the character, and the habits of the other. Personal congeniality is highly desirable because of the inevitable closeness of the working arrangement.

Once the above considerations have been duly weighed, the matter should be carefully discussed with an attorney. If the latter should not be familiar with certain of the ethical and other considerations which distinguish medical practice and which should carry over into medical partnerships, the physicians should inform their attorney on such points. It is also believed prudent, in terms of time saving and tax saving, to have partnership books established and periodically audited by a certified public accountant.

Partnerships which are entered into with the care above indicated and recommended should have a correspondingly greater likelihood of successful operation and survival.

Salary Ceilings and Doctors*

WAGE and salary ceilings set under the Defense Production Act are not applicable to most physicians. The act, under its Title IV, specifically exempts the following:

"Rates or fees for professional services; wages, salaries and other compensation paid to physicians employed in a professional capacity by licensed hospitals, clinics, and like medical institutions for the care of the sick and disabled . . ."

Following are excerpts from Interpretation No. 1, issued September 28 by the Salary Stabilization Board, explaining which physicians are exempt and which are not:

Must Meet These Requirements

To be exempt, a physician must possess a license to practice medicine, granted by the jurisdiction where he is employed in a professional capacity, in the branch of the medical profession in the practice of which he is engaged.

The exemption extends to a physician only if he is employed in a professional capacity. A physician is employed in a professional capacity if he performs work which requires application of his medical knowledge and exercise of discretion or judgment, and which is predominantly intellectual and varied in character. Professional work must be the employee's primary duty and at least half of his time must be spent in professional work.

Generally, physicians employed by licensed hospitals on a salary basis either to treat hospital patients, as medical specialists, or as superintendents or administrators of hospitals are considered employed in a professional capacity and are included in the statutory exemption. Physicians employed in the same capacities by lawfully operated clinics and like medical institutions for the care of the sick or disabled are also exempt from salary stabilization.

These Are Not Exempt

On the other hand, employment of a physician by another physician carrying on his practice is not exempt. The statute does not apply to this relationship.

Physicians employed in the course of their employer's ordinary business other than those employed in a professional capacity by a licensed hospital, clinic or like medical institution for care of the sick or disabled are not covered by the exemption. Physicians employed both in a capacity exempt under the statute and in non-exempt employment remain under salary stabilization with regard to the latter employment.

The statute requires that a physician, to be exempt, must be employed either by a licensed hospital, clinic or like medical institution for the care of the sick or disabled.

A licensed hospital, clinic or like medical institution for the care of the sick or disabled may be operated not as an independent institution, but either primarily or entirely as a service for the employees of a business enterprise or for the members of a labor union. Physicians employed by such institutions are considered exempt as to their compensation, provided they are employed as physicians of the institution operated by their employer.

Physicians employed in a licensed hospital, clinic or like medical institution operated by a medical care foundation or plan or health insurance organization are likewise exempt.

Terms Defined

Relative to what is meant by the term "licensed hospital, clinic, etc." the interpretative statement explained as follows:

Hospitals must either be licensed by appropriate authority in the jurisdiction in which the hospital is operated, or, if no license is required by such authority, must comply with minimum standards of operation and be subject to supervision prescribed by local law.

Clinics and like medical institutions for the care of the sick or disabled must be operated in conformity with the requirements of any applicable local law. The exemption of physicians applies only to the hospital, clinic or like institution for the care of the sick or disabled which is operated in compliance with the foregoing.

Hospitals are medical institutions for the in-patient diagnosis and treatment of illness or bodily injury, furnishing room and board so as to allow patients to be given continuing medical or surgical care (including obstetrics) within the institution.

Still Others Not Exempt

Physicians employed by corporations or other organizations whose services are rendered elsewhere than in a licensed hospital, clinic or like medical institution are not exempt. Physicians employed by insurance companies to examine applicants for insurance or in workmen's compensation cases and physicians employed to write medical literature or carry on medical research for manufacturers of drugs and pharmaceutical products are business employees and are not exempt from stabilization.

Clinics are institutions performing medical services for the treatment of illness or bodily injury on an out-patient basis. As distinguished from hospitals, they are not equipped for in-patient care.

Like medical institutions for the care of the sick or disabled are institutions which combine medical treatment with general residential facilities, such

*Reprinted, with permission, from the December 1951 issue of the Ohio State Medical Journal.

as sanitaria for the treatment of tuberculosis patients, the mentally ill or other chronic ailments. They are generally considered hospitals by the medical profession.

Some institutions have for their primary purpose the furnishing of domiciliary care rather than medical treatment. Residence homes for the blind, for old people, for persons suffering similar confining disabilities or maternity homes are in this category and are not considered institutions for the care of the sick or disabled within the meaning of the statute.

Society Membership Enrolls in Group Disability Plan

IN THE supplement to the Wisconsin Medical Blue Book which was published as the January, 1951 issue of *The Wisconsin Medical Journal*, a short article appeared at page 67. It summarized the background and the principal features of the group disability or time loss program to which all Society members under age 75 were eligible.

At the expiration of another year, it has become possible to add a little more to the story. First of all, more than 80 per cent of the physicians eligible to enter the plan had done so when the last count was made. This is believed to be an exceptional response, and it is also felt that it has been achieved with minimum inconvenience to the membership. Second, the annual aggregate premium is somewhat in excess of $200,000.

August 15, 1951, marked the end of the first year after installation of the plan. The insurance company paid out about $101,000 to Society members for disability during that period, and estimated that its liability on pending cases would aggregate about another $45,000. The balance of the total premium is needed to establish reserves for future claims, and to pay insurance company administrative costs. It is thus evident that the plan meets a genuine need of the members of the Society, and that they are receiving substantial benefits from it.

At the risk of repetition, some of the principal features of the plan are taken from the 1951 article above referred to. They may be summarized as follows:

1. So far as is known, its weekly benefit of $75 is the highest available to those under 70 in any group plan written for physicians in this country.

2. So far as is known, it is the only group plan writing physicians after age 70.

3. The insuring clause is written in the broadest possible wording, thereby reducing the chance of disputes to a minimum.

4. No house confinement requirement is imposed.

5. New members of the Society under age 32 may enroll within one year, and new members over 32 within six months, without furnishing evidence of insurability.

6. Total disability caused by sickness is payable up to 104 weeks, or two years. Total disability caused by accident is payable up to 260 weeks, or five years. Partial disability caused by accident is payable up to 26 weeks at one-half the weekly indemnity.

There is no waiting period in accidental cases or in hospitalized sickness cases. Where total disability caused by sickness is cared for at home, benefits are not payable until the sixteenth day.

7. The annual cost for members under 70 is $99 for the disability and related coverage, and $17 for the hospitalization coverage, a total of $116. The annual premium for members between 70 and 75 is $77.50 for disability and related coverage, plus $17 for hospitalization, a total of $94.50. Physicians in either age group may pay the premiums semi-annually without the addition of interest or other charges.

8. The policy also contains a number of other desirable features, including waiver of premium after three months of continuous disability, for a period not exceeding that during which benefits would have been payable and a 31 day grace period while premiums are payable.

9. The insurance certificate of the individual physician cannot be cancelled, except for: non-payment of premium; attainment of age 75; ceasing to be an active member of the medical society or in the active practice of his profession; or the cancellation of the master contract. The latter can be cancelled only on the annual renewal date, and then only on notice of at least 60 days.

10. There are a number of collateral benefits, including accidental death and dismemberment, partial disability up to 26 weeks, and no prorating of benefits should the physician have one or more additional policies in force.

11. Hospital benefits of $10 a day up to 70 days per illness are provided, with $100 in additional hospital expenses over and above room and board.

12. From the standpoint of the insured physician, one of the most reassuring features of the master contract is the provision for investigation and review by the State Medical Society of any disputes between a claimant physician and the insurance company.

Provisions of Wisconsin General Hospital Law

ACCORDING to the provisions of chapter 142 and section 36.31, Wis. Stats., the State of Wisconsin General Hospital, located in Madison, was established for two primary purposes: (1) to furnish facilities for teaching and the advancement of medical knowledge; and (2) to furnish specialized facilities for the care and hospitalization of patients lacking such facilities within their own communities.

142.01 **Public patients.** (1) A person having a legal settlement in any county in this state who is crippled or ailing and whose condition can probably be remedied or advantageously treated, if he or the person liable for his support is financially unable to provide proper treatment, may be treated at the Wisconsin general hospital or the Wisconsin orthopedic hospital for children at Madison or in such other hospital or rehabilitation camp as the county judge shall direct, except that when the person to be treated, or his guardian if he be under guardianship, shall select that such treatment be at the said Wisconsin general hospital or the said Wisconsin orthopedic hospital or rehabilitation camp, the hospital or rehabilitation camp of his selection shall be the place of treatment; provided that the right of such selection shall not exist in counties having a population of five hundred thousand or more . . .

142.02 **Application.** When the case of such person shall come to the notice of the sheriff, county supervisor, town clerk, health officer, health nurse, poor commissioner, policeman, physician or surgeon, or any public official, he shall and any teacher, priest or minister may, file with the county judge of the county wherein such afflicted person has a legal settlement an application for such treatment at such hospital.

The judge then appoints a physician to investigate the physical condition of the patient. At the same time the judge makes an investigation as to the propriety of such a commitment. The supervisor of the town, village or ward of residence of the person is required to furnish the court, upon request, with all material information within his knowledge in order that the judge may intelligently decide the case. If the judge is satisfied that the patient or the person liable for his support is financially unable to provide proper treatment and upon recommendation of the physician that the patient is a proper person for hospitalization at the State of Wisconsin General Hospital, the judge shall then issue an order approving such hospitalization, in which instance the cost is borne equally by state and county, provided that the county has not exceeded its quota for that year.

Unless the case is an emergency, the hospital desires the court order certifying the patient to the institution prior to the arrival of the patient. This allows the hospital to delay admission in certain cases where the services are already overcrowded.

Patients are also admitted to the hospital upon receipt of a letter from the family physician stating that the patient can pay $16.00 a day, in advance, for hospitalization, but that a professional fee or extras in addition would be a severe hardship. A few private cases are also admitted, but the hospital is not primarily interested in this type of work. Address all communications to the office of the Superintendent, 1300 University Avenue, Madison, Wisconsin.

Classification of patients admitted to the hospital is given below:

1. *County-state patient:* Hospitalization is authorized by the county judge of the county in which patient resides. Hospitalization costs are paid equally, half by the county and half by the state until that county's quota for that year is exhausted in which case the county bears the full cost.

2. *Special rate patient* (formerly called the "clinic case"): This type of patient comes to the hospital on his physician's recommendation that he be accepted on $16.00 per day basis. A financial statement of the patient is taken on admission, and if it is felt that his status justifies a $16.00 per day charge, he is admitted on that basis. He is thereby entitled to every service except transfusions and special nursing.

3. *Private patient:* This type of patient is handled the same as would be the case in any other hospital *except* that he is accepted only on reference or recommendation of the physician in the home community.

4. *War Veterans:* Any honorably discharged veteran of any war of the United States, who has been a resident of the state for not less than five years preceding his admission, may be admitted to the hospital and obtain all care including professional service at the established per diem rate ($5.90). War veterans are required to present their honorable discharge papers and sign a statement declaring residency for the last five years preceding admission to the hospital. War veterans may be admitted as private patients of individual staff members if properly referred, in which case hospital rate is as above, but professional fee applies.

No patient is accepted at Wisconsin General Hospital unless referred or recommended by the patient's physician, except in case of emergency or accident where delay may cause serious complications.

Divisions of Wisconsin General Hospital

Wisconsin General Hospital: Admissions per above; general hospital service plus teaching privileges in connection with the University.

Wisconsin Orthopedic Hospital: Orthopedic and plastic surgery patients only. All patients admitted through the regular admitting channels of the Wisconsin General Hospital and with the approval of the Crippled Children's Division.

Bradley Memorial Hospital: This is the psychiatric unit of the Wisconsin General Hospital and not a separate unit.

University of Wisconsin Infirmary: Student health center and hospital.

Wisconsin Psychiatric Institute: Furnishes facilities for blood and spinal fluid Wassermann examinations for the various state agencies and institutions, and for any physician desiring its facilities.

Treatment May Be at Home or in Local Institution

Under the Wisconsin General Hospital Law (sections 142.01 and 142.04) a person having a legal settlement in any county, who is crippled or ailing and whose condition can probably be remedied or treated advantageously, and for whom treatment is financially impossible, may be confined, as the situation warrants, in the Wisconsin General Hospital, in the Wisconsin Orthopedic Hospital, in a local institution or at home.

Conditions Necessary to Local Treatment

Where treatment is to be given at home or in a local institution, the court must find that such treatment will be adequate and at the same or less expense to the county. But it must be kept in mind that the law is beneficent, and must be construed to give effect to its purpose. Thus the Attorney General has held that treatment need not be ordered at Madison in the emergency case, even though the expense might be less than in a local institution, because "it is not believed that the treatment at Madison would be considered adequate. . . ." (XXII Atty. Gen. 465). And in the consideration of "expense," the county judge may take into account the costs necessary to remove a patient to Madison, for transportation expense, and those of an attendant, both to and from the institution, are not items of joint state and county expense.

The County Quota

Under the provisions of the law, state aid ceases when the total county patients committed from any one county exceeds a ratio of more than two persons per thousand of population or major fraction thereof, although there is no limit if there is no hospital in the county concerned nor as to patients certified to the Wisconsin Orthopedic Hospital. The decision whether there is a hospital in the county is for the secretary of state at the time he certifies to the county its share of the costs. 30 Atty. Gen. 98. If the county exceeds its quota, then the county must pay the entire cost of hospitalization if the patient is to be confined in Madison. If the patient is confined at home under the provisions of the law, no expense of hospitalization is involved at all. The only expense to the county would be that of medical care and nursing.

Physicians' Fees

In proceedings under the Wisconsin General Hospital Law, two entirely separate and distinct fees are permitted physicians.

By provisions of section 142.03 (2) the county judge, if satisfied that a patient presents a proper situation, "shall appoint a physician personally to examine the person." By statute, the physician is directed to make a verified report in writing giving certain required information, and shall "be paid by the county $5.00 and actual and necessary expenses." Since no method is provided for the payment of the physician, he must proceed through legal channels for the collection of the $5.00 fee allowed. Following the provisions of section 59.77 (1), dealing with claims against the county, the physician must make a statement of his claim in writing upon county voucher forms setting forth its nature and the facts upon which it is founded. If the claim includes mileage, the statement should specify the days and places, so as to show between what points, and when, and the purpose for which the travel charges were made. Since the fee is statutory, the time expended in the performance of service need not be stated. But the statement must be verified by affidavit and filed with the county clerk, whose duty it is, under the provisions of section 59.79 to transmit the same to the county board.

The expense of treatment of such patients, in local institutions or at home, shall be paid by the county treasurer, upon the certificate of the county judge who shall be satisfied as to the correctness and reasonableness thereof. The claim of the physician rendering the treatment need not be passed upon by the county board, but only by the county judge. See sections 142.04 and 142.08 (5). See also 21 Atty. Gen. 240 and 22 Atty. Gen. 408.

EPILEPTICS AND THE STATE MOTOR VEHICLE DEPARTMENT

No one who is subject to epileptic seizures may be licensed to drive a motor vehicle in Wisconsin, except under the following conditions:

If an epileptic is under medical care, however, and while under medication is free from seizures, and his driving is not otherwise a hazard to public safety, he may be issued a temporary license, which must be recertified each six months. Section 85.08 (6) (j) of the Wisconsin Statutes, enacted during the 1949 session of the Legislature, provides that any physician licensed in this state may recommend such a temporary license for a patient on a combined questionnaire and recommendation form provided by the Motor Vehicle Department.

The issuance of a temporary license, predicated upon such a recommendation by the physician rendering treatment, is discretionary with the Motor Vehicle Department, but a denial may be reviewed by a special board, two of the three members of which are designated by the president of the State Board of Health.

The State Medical Society of Wisconsin

1952 Officers and Councilors

President

Dr. A. H. Heidner
West Bend

President–Elect

Dr. J. C. Griffith
944 North Jackson Street
Milwaukee

Secretary

Mr. C. H. Crownhart
704 East Gorham Street
Madison 3

Assistant Secretary

Mr. Roy T. Ragatz
704 East Gorham Street
Madison 3

Treasurer

Dr. F. L. Weston
1300 University Avenue
Madison 6

Speaker, House of Delegates

Dr. H. Kent Tenney
1 South Pinckney Street
Madison 3

Councilors*

(Dr. R. G. Arveson, Frederic, Chairman)

First: Dodge, Jefferson and Waukesha County Societies. Dr. W. H. Costello, Beaver Dam, 1954.

Second: Kenosha, Racine and Walworth County Societies. Dr. T. C. Hemmingsen, 1332 State Street, Racine, 1954.

Third: Dane, Columbia–Marquette–Adams, Green, Rock and Sauk County Societies, Dr. H. Kent, Tenney, 1 South Pinckney Street, Madison, 1952; Dr. H. E. Kasten, 419 Pleasant Street, Beloit, 1954.

Fourth: Crawford, Grant, Iowa, Lafayette and Richland County Societies. Dr. E. M. Dessloch, Prairie du Chien, 1952.

Fifth: Calumet, Manitowoc, Sheboygan and Washington–Ozaukee County Societies. Dr. A. H. Heidner, West Bend, 1952.

Sixth: Brown–Kewaunee–Door, Fond du Lac, Outagamie and Winnebago County Societies. Dr. A. J. McCarey, 610 Northern Building, Green Bay, 1952.

Seventh: Juneau, La Crosse, Monroe, Trempealeau–Jackson–Buffalo and Vernon County Societies. Dr. J. C. Fox, 508 Batavia Bank Building, La Crosse, 1953.

Eighth: Marinette–Florence, Oconto and Shawano County Societies. Dr. J. M. Bell, Peshtigo, 1953.

Ninth: Clark, Green Lake–Waushara, Lincoln, Marathon, Portage, Waupaca and Wood County Societies. Dr. E. E. Kidder, 313 Main Street, Stevens Point, 1953.

Tenth: Barron–Washburn–Sawyer–Burnett, Chippewa, Eau Claire–Dunn–Pepin, Pierce–St. Croix, Polk and Rusk County Societies. Dr. R. G. Arveson (chairman) Frederic, 1953.

Eleventh: Ashland–Bayfield–Iron and Douglas County Societies. Dr. V. E. Ekblad, 1507 Tower Avenue, Superior, 1954.

Twelfth: The Medical Society of Milwaukee County. Dr. R. E. Galasinski, 1227 West Lincoln Avenue, Milwaukee; Dr. E. L. Bernhart, 2714 West Burleigh Street, Milwaukee; Dr. N. J. Wegmann, 2510 West Capitol Drive, Milwaukee, 1954; Dr. D. F. Pierce, Hales Corners, 1952.

Thirteenth: Forest, Langlade, Oneida–Vilas and Price–Taylor County Societies. Dr. C. E. Zellmer, Antigo, 1953.

Dr. H. H. Christofferson (Past President), Colby.

Dr. S. E. Gavin, 104 South Main Street, Fond du Lac, Chairman Emeritus.

Delegates to American Medical Association

Dr. S. E. Gavin (1952)
104 South Main Street
Fond du Lac

Dr. W. D. Stovall (1953)
Service Memorial Institute
Madison 6

Dr. D. H. Witte (1952)
3300 West Wisconsin Avenue
Milwaukee

Alternates

Dr. L. O. Simenstad (1952)
Osceola

Dr. Joseph C. Griffith (1952)
944 North Jackson Street
Milwaukee

Dr. D. J. Twohig (1953)
Fond du Lac

* Map indicating location of councilor districts, page 95.

Standing Committees—1951-1952

Committee on Cancer

A. R. Curreri, M.D., 1952, chairman, 1300 University Avenue, Madison
W. S. Bump, M.D., 1953, 1020 Kabel Avenue, Rhinelander
L. J. Van Hecke, M.D., 1953, 161 West Wisconsin Avenue, Milwaukee
D. C. Beebe, M.D., 1953, Sparta
S. L. Henke, M.D., 1953, 314 East Grand Avenue, Eau Claire
A. C. Taylor, M.D., 1954, 103 West College Avenue, Appleton
R. P. Welbourne, M. D., 1954, 113 North Third Street, Watertown
P. B. Blanchard, M.D., 1954, Cedarburg
W. E. Bargholtz, M.D., 1954, 522 West Second Avenue, Ashland
G. L. McCormick, M.D., 1952, Marshfield
K. G. Pinegar, M.D., 1952, Marinette
J. W. Conklin, M.D, 1953, Platteville
G. C. Schulte, M.D., 1953, 7221 Third Ave., Kenosha

Advisory Committee on Care of Crippled Children

H. A. Sincock, M.D., 1954, chairman, 1507 Tower Avenue, Superior
A. B. Schwartz, M.D., 1953, 1513 East Capitol Drive, Milwaukee
C. M. Kurtz, M. D., 1954, Wisconsin General Hospital, Madison 3
W. P. Blount, M.D., 1952, 324 East Wisconsin Avenue, Milwaukee 2
C. M. Ihle, M.D., 1952, 314 East Grand Avenue, Eau Claire
R. E. Housner, M.D., 1953, Richland Center

Committee on Goiter

A. S. Jackson, M.D., 1956, chairman, 16 South Henry Street, Madison
T. J. Pendergast, M.D., 1952, 2317 North One Hundred-First Street, Wauwatosa 13
B. J. Peters, M.D., 1953, 2010 Ludington Avenue, Wauwatosa 13
O. E. Satter, M.D., 1954, Prairie du Chien
Vacancy
C. N. Neupert, M.D., ex officio, 1 West Wilson Street, Madison 2
E. S. Gordon, M.D., ex officio, 1300 University Avenue, Madison 6

Committee on Grievances

R. E. Fitzgerald, M.D., 1954, chairman, 2218 North Third Street, Milwaukee 12
E. W. Mason, M.D., 1953, 324 East Wisconsin Avenue, Milwaukee 2
F. A. Nause, M.D., 1952, 925 North Eight Street, Sheboygan
C. E. Zellmer, M.D., 1954, Antigo
E. D. Sorenson, M.D., 1953, Elkhorn
H. W. Wirka, M.D., 1952, Wisconsin General Hospital, Madison 6

Committee on Hearing Defects

T. L. Tolan, M.D., 1953, chairman, 324 East Wisconsin Avenue, Milwaukee 2
W. C. Randolph, M.D., 1952, 819 Hancock St., Manitowoc
G. B. Ridout, M.D., 1956, 1836 South Avenue, LaCrosse
J. A. Hurlbut, M.D., 1955, 16 South Henry Street, Madison
J. W. Tanner, M.D., 1954, 314 E. Grand Avenue, Eau Claire

Committee on Hospital Relations

Karl H. Doege, M.D., 1953, chairman, 650 South Central Avenue, Marshfield
A. H. Barr, M.D., 1954, 214 North Wisconsin Street, Port Washington
S. R. Beatty, M.D., 1954, Mercy Hospital, Oshkosh
K. F. Manz, M.D., 1952, Neillsville
Gorton Ritchie, M.D., 1953, Columbia Hospital, Milwaukee 11
P. C. Dietz, M.D., 1952, St. Francis Hospital, La Crosse

Committee on Maternal and Child Welfare

L. M. Simonson, M.D., 1954, chairman, Sheboygan Clinic, Sheboygan
R. F. Purtell, M.D., 1953, 758 North Twenty-seventh Street, Milwaukee 8
Amy Louise Hunter, M.D., 1953, State Office Building, Madison 2
J. W. Harris, M.D., 1954, 1300 University Avenue, Madison 6

A. H. Stahmer, M.D., 1952, 310½ South First Avenue, Wausau
Mildred Stone, M.D., 1952, 2103 Rowley Avenue, Madison

Committee on Medical Education and Hospitals

T. L. Squier, M.D., 1956, 425 East Wisconsin Avenue, Milwaukee 2
J. K. Trumbo, M.D., 1952, Wausau
A. H. Heidner, M.D., 1953, West Bend
Norman Becker, M.D., 1954, 104 South Main Street, Fond du Lac
J. W. Boren, Jr., M.D., 1955, 1510 Main Street, Marinette
W. S. Middleton, M.D., ex officio, 1300 University Avenue, Madison 6
J. S. Hirschboeck, M.D., ex officio, 561 North Fifteenth Street, Milwaukee 3

Committee on Coordination of Medical Services

S. B. Harper, M.D., 1953, chairman, 1 Woodward Grove, Madison 3
S. E. Gavin, M.D., 1956, 104 South Main Street, Fond du Lac
F. W. Kundert, M.D., 1952, 921 Sixteenth Avenue, Monroe
W. H. Costello, M.D., 1954, Beaver Dam
T. W. Tormey, M.D., 1955, 16 North Carroll Street, Madison 3
President, ex officio
Secretary, ex officio

Council on Medical Services

D. E. Dorchester, M.D., 1954, chairman, Sturgeon Bay
R. L. MacCornack, M.D., 1954, Whitehall
C. G. Reznichek, M.D., 1954, 2037 Winnebago Street, Madison 4
T. D. Elbe, M.D., 1953, Thiensville
L. O. Simenstad, M.D., 1953, Osceola
Maurice Hardgrove, M.D., 1952, 208 East Wisconsin Avenue, Milwaukee 2
T. E. Gundersen, M.D., 1952, 1836 South Avenue, La Crosse
D. M. Willison, M.D., 1952, 314 East Grand Avenue, Eau Claire
D. N. Goldstein, M.D., 1953, 625 Fifty-Seventh Street, Kenosha

Committee on Mental Hygiene, Institutional Care, Public Welfare, and State Departments

A. M. Christofferson, M.D., 1953, chairman, Waupaca
P. R. Minahan, M.D., 1955, 347½ South Washington Street, Green Bay
Joseph Lettenberger, M.D., 1956, 1560 West Greenfield Avenue, Milwaukee 7
B. J. Hughes, M.D., 1952, Winnebago State Hospital, Winnebago
E. D. Schwade, M.D., 1954, 324 East Wisconsin Avenue, Milwaukee 2

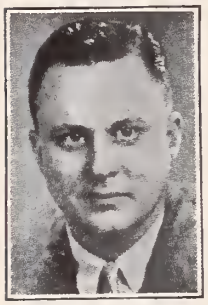
Committee on Public Policy

J. M. Sullivan, M.D., 1952, 161 West Wisconsin Avenue, Milwaukee 3
M. G. Rice, M.D., 1954, 401 Main Street, Stevens Point
J. K. Curtis, M.D., 1956, 3301 Topping Road, Madison
S. E. Gavin, M.D., 1955, 104 South Main Street, Fond du Lac
J. R. Schroeder, M.D., 1953, 500 West Milwaukee Street, Janesville
President, ex officio
President-elect, ex officio
Secretary, ex officio

Council on Scientific Work

W. S. Bump, M.D., 1952, chairman, Rhinelander
T. O. Nuzum, M.D., 1953, 500 West Milwaukee Street, Janesville
J. W. Gale, M.D., 1954, 1300 University Avenue, Madison 6
S. A. Morton, M.D., 1956, 3321 North Maryland Avenue, Milwaukee 11
P. A. Midelfart, M.D, 1955, 314 East Grand Avenue, Eau Claire
R. S. Baldwin, M.D., ex officio, 650 South Central Avenue, Marshfield
J. S. Hirschboeck, M.D., ex officio, 561 North Fifteenth Street, Milwaukee 3
W. S. Middleton, M.D., ex officio, 1300 University Avenue, Madison 6

Committee on Tuberculosis and Chest Diseases



J. D. Steele, M.D., 1953, chairman, 1705 West Wisconsin Avenue, Milwaukee 3

A. A. Pleyte, M.D., 1956, 1018 North Jefferson Street, Milwaukee 2

W. T. Clark, M.D., 1952, 20 East Milwaukee Street, Janesville

H. A. Anderson, M.D., 1954, River Pines Sanitarium, Stevens Point

L. W. Moody, M.D., 1955, Bayfield

Special Committee of the President on Public Assistance Aids

C. W. Aageson, M.D., chairman, 1 South Pinckney Street, Madison

J. F. Hildebrand, M.D., 1011 North Eighth Street, Sheboygan

W. H. Pollard, M.D., 602 East Grand Avenue, Beloit

T. F. Farrell, M.D., Prairie du Chien

K. G. Pinegar, M.D., Marinette

C. A. Olson, M.D., Baldwin

Advisory Committee to Woman's Auxiliary

Chairman of the Council, chairman
Immediate past-president
President
President-elect
Secretary

Committee on Visual Defects

J. B. Hitz, M.D., 1956, chairman, 1324 West Wisconsin Avenue, Milwaukee 2

E. J. Zeiss, M.D., 1952, 103 West College Avenue, Appleton

H. J. Belson, M.D, 1953, 904 South Eighth Street, Manitowoc

T. J. Doyle, M.D., 1954, 1507 Tower Avenue, Superior

T. B. McNamara, M.D., 1955, 205 South Fifth, La Crosse

Council Committees

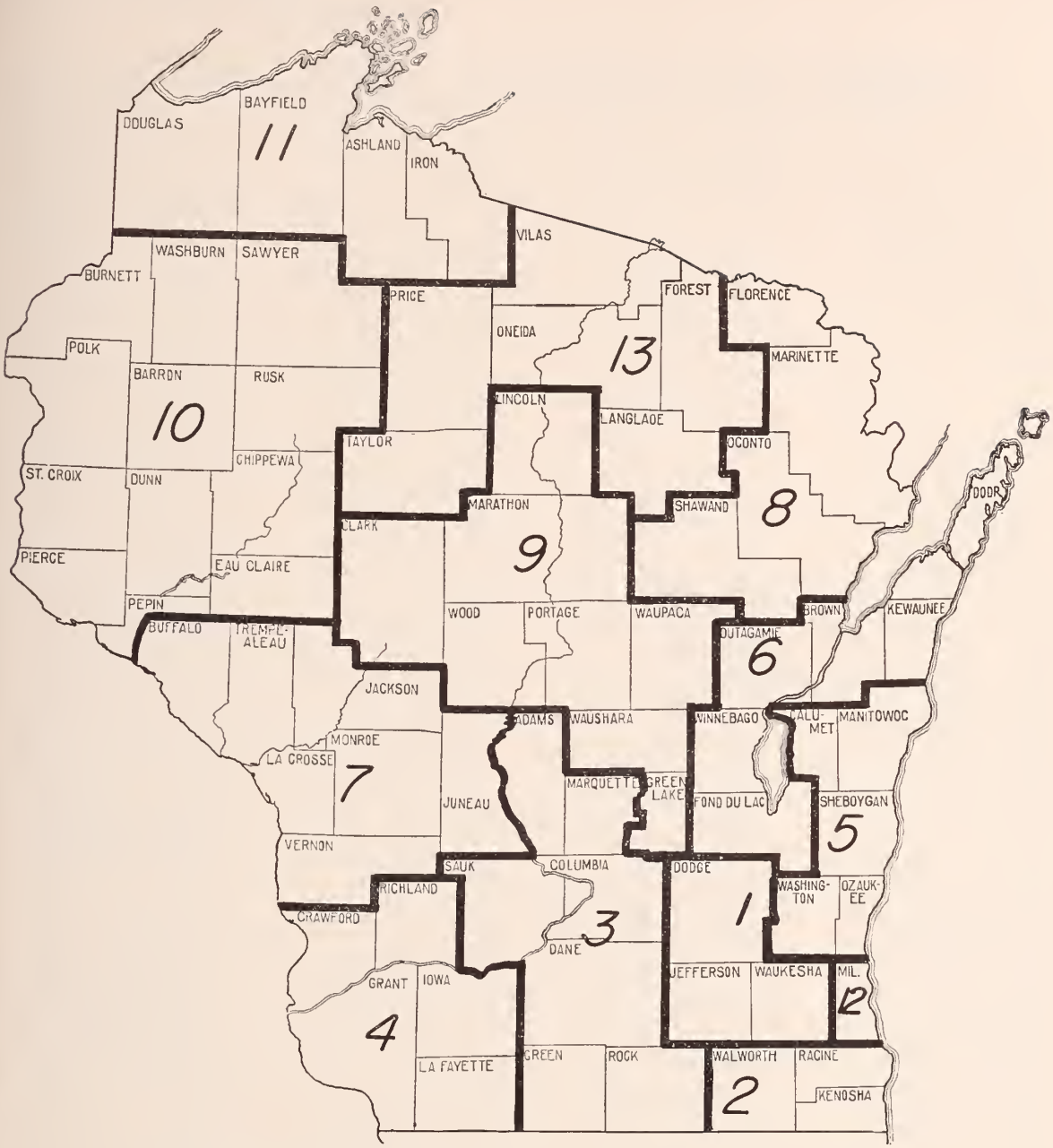
The following committees are committees of the Council. Appointments are made by the chairman of the Council following its annual meeting in February, and names of committee members are published in the March issue of the *Journal.*

Advertising
Advisory to the Department of Veterans Affairs
Audit and Budget
Blood Bank
Civil Defense
Commission on Prepaid Plans
Editorial Board
Group Insurance
Historical
Interim Committee
Military Medical Service
Polio Consultants
School Health
Venereal Diseases
Veterans Medical Service Agency

IDENTIFICATION BY BLOOD TEST

Whenever relevant to the prosecution by the mother, or defense by the alleged father, in an illegitimacy action, the trial court may order the mother, child and alleged father to submit to one or more blood tests to determine whether the defendant can be excluded as the father of the child. The results of the test are admissible only to prove that the defendant is not the father; the results of a test which show only that the defendant might be the father are not admissible. Such tests are conducted by a physician or physicians, licensed to practice medicine and surgery, or by another duly qualified person or persons, not to exceed three, who are appointed by the court and paid by the county. Sec. 166.105, statutes.

Whenever relevant in a civil action to determine the parentage or identity of any child, person or corpse, the court may direct any person or persons involved to submit to one or more blood tests under restrictions and directions deemed proper by the court. Only where definite exclusion of the person involved in the controversy is established by the test are its results receivable in evidence. Sec. 325.23, statutes.



MAP INDICATING LOCATION OF COUNCILOR DISTRICTS

First District:
Dr. W. H. Costello, Beaver Dam

Second District:
Dr. T. C. Hemmingsen, Racine

Third District:
Dr. H. Kent Tenney, Madison
Dr. H. E. Kasten, Beloit

Fourth District:
Dr. E. M. Dessloch, Prairie du Chien

Fifth District:
Dr. A. H. Heidner, West Bend

Sixth District:
Dr. A. J. McCarey, Green Bay

Seventh District:
Dr. J. C. Fox, La Crosse

Eighth District:
Dr. J. M. Bell, Peshtigo

Ninth District:
Dr. E. E. Kidder, Stevens Point

Tenth District:
Dr. R. G. Arveson, Chairman, Frederic

Eleventh District:
Dr. V. E. Ekblad, Superior

Twelfth District:
Dr. R. E. Galasinski, Milwaukee
Dr. E. L. Bernhart, Milwaukee
Dr. N. J. Wegmann, Milwaukee
Dr. D. F. Pierce, Hales Corners

Thirteenth District:
Dr. C. E. Zellmer, Antigo

Dr. S. E. Gavin, Chairman emeritus, Fond du Lac

Members, State Medical Society of Wisconsin*

Abbotsford:
Shields, G. G.

Adams:
Ingersoll, B. P.

Adell:
Bemis, I. M.
Naylen, F. J.

Albany:
Bongiorno, F. J.

Algoma:
Pudleiner, H. G.
Stiehl, C. W.

Allenton:
Fisher, R. S.

Alma:
Bachhuber, M. O.

Amery:
Cornwall, W. B.
Dasler, H. A.
Ford, K. K.
Kremser, V. C.
Marra, M. G.
Whitlark, F. L.

Amherst:
Osicka, S. R.

Antigo:
Bloor, E. G.
Curran, W. P.
Donohue, M. J.
Dorzeski, E. F.
Garbisch, F. H.
Lambert, J. W.
McInnis, W. R.
McKenna, E. A.
Moore, G. E.
Zellmer, C. E.

Appleton:
Adrians, W. A.
Aldridge, C. W., Jr.
Benton, J. L.
Bolton, E. L.
Carlson, G. W.
Cunningham, P. M.
Dafoe, W. A.
DeCock, R. D.
Dehne, W. O.
Felton, W. C.
Frawley, W. J.
French, G. A.
Gallaher, D. M.
Giffin, W. S.
Gmeiner, J. E.
Gross, H. T.
Haentzschel, L. E.
Harrington, Wm. J.
Hauch, F. M.
Hegner, G. T.
Huberty, F. J.
Kagen, M. S.
Konz, S. A.
Krueger, E. N.
Laird, J. W.
Landis, R. V.
MacLaren, J. B.
Marshall, F. S
Marshall, V. F.
McBain, L. B.
Mielke, E. F.
Neidhold, C. D.
Pardee, C. A.
Rankin, F. J.
Reeve, J. S.
Skibba, J. P.
Swanton, M. E.
Taylor, A. C.
Williams, L. P.
Young, J. J.
Zeiss, E. J.

Arcadia:
Comstock, Elizabeth
Dockendorff, B. C.
Haines, B. J.
Weber, F. T.

Argyle:
Thompson, L. L.

Arpin:
Ryan, C. J.

Ashland:
Andrus, A. D.
Bargholtz, W. E.
Burns, D. H.
Butler, Albert
Grand, C. A.
Grigsby, R. O.
Harrison, G. W.
Jauquet, J. M.
Kreher, J. E.
Merrill, W. G.
Prentice, J. W.
Sandin, H. V.
Smiles, C. J
Tucker, W. J.
Weeks, F. D.

Athens:
Bachhuber, G. J.
Bachhuber, H. M.

Augusta:
Emanuel, D. E.
Moland, O. G.
Thieda, E. S.

Bailey's Harbor
Fillbach, H. E.

Baldwin:
Olson, C. A.
Sargeant, G. M.

Bangor:
Ruppenthal, K. P.

Barahoo:
Carstens, E. H.
Edwards, A. C.
Hannan, K. D. L.
Huth, M. F.
McGonigle, B. E.
Moon, J. F.
Pearson, C. R.
Sporleder, O. F.
Tryon F E.
Vander Kamp, Harry

Barron:
Fostvedt, G. A.
Guy, J. R.
Mahaffey, C. H.
Radke, Lucille M.
Smith, R. C.
Strang, G. J.
Templeton, H. M.

Bayfield:
Moody, L. W.

Bear Creek:
Morneau, L. F.

Beaver Dam:
Bayley, H. G.
Bender, R. I.
Bergen, P. V.
Boock, R. F.
Corso, Xavier
Costello, W. H.
Davis, T. C.
Drescher, G. G.
Foley, M. E.
Hoyer, A. A.
Hoyer, E. C.
Kores, A B.
Qualls, C L.
Roberts, R. R.
Rosenheimer, A. M.
Schoen, R. F.
Urbanek, R. E.
Webb, E. P.
Weisch, J. M.

Belgium:
Dorr, R. H.

Belleville:
Donlin, W. F.

Belmont:
Turgeson, J. F.

Beloit:
Allen, W. J.
Brillman, L. P.
Carney, C. M.
Carter, K. L.
Clark, D. M.
Cochrane, W. L.
Crockett, W. W.
Fitzgerald, W. M.
Flarity, T H.
Fosse, Benjamin
Friend, L. J.
Gunderson, R. H.
Helm, H M
Ingersoll, R. S.
John, G W.
Johnson, F. K.
Jones, E. T.
Kasten, H. E.
Kishpaugh, H. W.
Mauermann, W. J.
McGaughey, C. G.
Ottow, A. F.
Peterson, G. H.
Pollard, W. H., Jr.
Pranke, D. W.
Raube, H A
Rechlitz, E. T.
Ross, M E.
Sanderson, R. J.
Shearer, H. A.
Springberg, J. C.
Sweeney, T. C.
Thayer, R. A.
Thompson, I. F.
Thomson, G. H.
Twyman, A. H.
Vivian, R. S.
Wilson, R. F.

Berlin:
Koch, H. C.
Seward, L. J.
Sievers, D. J.
Stone, G. C.
Taugher, V. J.
Wiesender, A. J.

Big Bend:
Boldt, R. E.

Birnamwood:
Damp, O. E.

Black Creek:
Smith, P. W.

Black River Falls:
Krohn, Robert
Marks, J. R.

Blair:
Schneider, O. M.

Blanchardville:
Unterholzner, L. J.

Bloomer:
Clauson, C. T.
Hudek, D. F.

Bloomington:
Brooks, E. H.
Edwards, P. K.

Bonduel:
Terlinden, J. H.

Boscobel:
Freymiller, E. F.
Hayman, C. S.
McNamee, J. R.
Randall, E. M.
Randall, M. W.

Boulder Junction:
Newcomb, Kate P.

Boyceville:
Williams, A. F

Brandon:
Lautenbach, E. T.

Brillion:
Guthrie, J. M.
Keller, L. W.
Langmack, W. A.

Brodhead:
Stovall, W. D., Jr.
Stuessy, M. W.

Brownsville:
Friedrich, L. E.
Raymond, R. G.
Ries, M. F.

Bruce:
Whalen, M. L.

Burlington:
Bennett, J. F.
Carroll, J. H.
Erickson, L. W.
Granzeau, H. W.
Mastalir, L. O.
Murawsky, W. J.
Newell, F. F.

Butler:
Schoeneman, R. H.

Cadott:
Rahn, B. F.
Zenner, C. E.

Cambria:
Pavelsek, J. W.

Cambridge:
Amundson, K. K.
Bilstad, G. E.

Cameron:
Cronk, C. F.

Campbellsport:
Guenther, O. F.
Hoffmann, L. A.

Casco:
Kerscher, E. J.
Majeski, H. E.

Cashton:
Mauel, N. M.

Cassville:
David, J. J.

Cedarburg:
Blanchard, P. B.
Hurth, O. W.
Katz, H. J.

Cedar Grove:
Jensen, J. S.
Voskuil, Anthony

Centuria:
Noyes, G. B.

Chaseburg:
Richter, J. R.

Chetek:
Adams, R. W.
Balken, J. B.

Chilton:
Goggins, J. W.
Humke, E. W.
Humke, K. R.
Knauf, N. J.
Minahan, J. J.
Rathert, E. T.

* As of December 31, 1951.

Chippewa Falls:
Brown, F. J.
Field, Merton
Graber, R. E.
Hatleberg, C. B.
Hatleberg, E. J.
Henske, W. C.
Janc, W. F.
Kelly, J. A.
Kemper, C. A.
McHugh, F. T.
Picotte, L. W.
Sazama, F. B.
Sazama, J. J.
Williams, S. E.

Clear Lake:
Campbell, L. A., Jr.

Cleveland:
Feider, A. P.

Clinton:
Thomas, W. O.

Clintonville:
Auld, Irving
Bate, L. C.
German, J. D.
Miller, E. A.
Pfeifer, R. H.
Topp, C. A.

Cochrane:
Meili, E. A.

Colby:
Christofferson, H. H.
Lehmer, R. A.

Coleman:
Graner, L. H.

Colfax:
Cooper, C. A.
Felland, O. M.

Columbus:
Caldwell, H. M.
Cheli, C. F.
Mudroch, J. A.
Poser, E. M.
Poser, J. F.
Poser, R. F.

Cornell:
Foster, T. D.

Crandon:
Ison G. W
Moffet, D. V.
Rathert, Berton S.

Cross Plains:
Froggatt, W. E. L.
Lappley, W. F.

Cuba City:
King, C. S
Terry, R. E.

Cudahy:
Ackerman, D. S.
Ackerman, E. J.
Fine, J. M.
Kash, S. H.
Landsberg, Manfred
Partridge, C. D.

Cumberland:
Lund, R. E.
Lund, S. O.
Thompson, R. C.

Darien:
Truex, G. O.

Darlington:
McConnell, E. D.
McGreane, N. A.

Deerfield:
Ingwell, C. L.

De Forest:
Cooney, R. T.
Grinde, J. M.

Delafield:
Barnes, H. T.
Olsen, L. C. J.

Delavan:
Crowe, N. F.
Galgano, R. S.
Jacobson, T. L.
Kenney, H. J.
Levin, H. M.
Moses, R. A.
O'Keefe, F. L.
Werbel, H. J.

Denmark:
Hering, G. V.
Hipps, C. J.
Michna, C. T.

De Pere:
Elders, W. F.
Merline, G. B.
Waldkirch, B. P.
Waldkirch, R. M.

De Soto:
Bolstad, H. A.

Dodgeville:
Hamilton, W. P.
Jackson, S. C.
Morton, H. H.
Walker, H. M.

Dorchester:
Foley, F. P.

Dousman:
Notbohm, W. R.
Watry, T. D.

Durand:
Bryant, R. J.

Eagle:
Fitzgerald, J. J.

Eagle River:
Burnett, C. H.
Colgan, J. J.
Oldfield, R. A. A.

East Ellsworth:
Klaas, F. B.

East Troy:
Kohn, Louis

Eau Claire:
Anderson, F. G.
Beebe, G. W.
Blom, Julius
Buckley, R. A.
Cameron, W. G.
Derge, H. F.
Durham, R. A.
Falstad, C. H.
Finucane, P. J.
Frank, R. C.
Fuson, H. S.
German, K. L.
Haag, A. F.
Hayes, E. P.
Henke, S. L.
Hilker, A. W.
Huston, H. C.
Ihle, C. M.
Kennedy, R. L.
Kinsman, F. C.
Klein, A. J.
Lotz, R. M.
Lowe, J. W.
Manz, W. R.
Mason, E. L.
Mautz, W. T.
Midelfart, Peter
Nester, H. D.
Nezworski, L. G.
Niver, E. O.
Paulson, W. O.
Richards, R. R.
Russell, S. B.
Sorensen, H. E.
Spelbring, P. G.
Strand, R. C.
Tanner, J. W.
Wahl, G. E.
Willison, D. M.
Wishart, J. H.
Ziegler, J. E. B.

Edgar:
Schulz, H. A.

Edgerton:
Burpee, G. F.
Cohen, D. A.
Falk, V. S., Jr.
Shearer, A. T.
Shearer, F. E.
Sumner, W. C.

Elcho:
Dailey, D. W.
Dailey, P. J.

Elkhart Lake:
Martineau, J. E.

Elkhorn:
Bertolaet, E. E.
Bill, K. C.
Helmhrecht, M. G.
Rawlins, J. A.
Sorenson, E. D.
Young, J. H.

Ellsworth:
Aanes, A. R.

Elm Grove:
Grade, J. O.
Kriz, G. A.
Zurheide, H. J.

Elmwood:
Breed, A. L.
Springer, F. A.

Elroy:
Demke, R. L.
Vogel, C. A.

Ettrick:
Rogne, C. O.

Evansville:
Gray, R. J.
Sorkin, S. S.

Fall Creek:
Zboralske, F. F.

Fennimore:
Bailey, M. A.
Howell, E. C.

Fond du Lac:
Becker, N. O.
Borsack, K. K.
Cerny, F. J.
Connell, John W.
Devine, H. A.
Devine, J. C.
Finn, W. C.
Flanagan, C. M.
Folsom, W. H.
Gardner, L. C.
Gavin, S. E.
Guth, H. K.
Hafemeister, E. F.
Huebner, J. S.
Hutter, A. M.
Keenan, L. J.
Kief, H. J.
Leonard, C. W.
McCabe, L. B.
McCormick, D. W.
McCullough, James C.
McCullough, John C.
Meiklejohn, D. V.
Pawsat, E. H.
Schroeder, R. W.
Sharpe, H. R.
Sharpe, H. R., Jr.
Sharpe, J. J.
Smith, E. V., Jr.
Steube, R. W.
Swan, J. C.
Theisen, S. A.
Twohig, D. J.
Twohig, D. J., Jr.
Twohig, J. E.
Vetter, E. W.
Waffle, R. L.
Waldschmidt, W. J.
Walters, D. N.
Wier, J. S.
Wojta, W. C.
Yockey, J. C.

Footville:
Harvey, J. R.

Forestville:
Hirschboeck, J. G.

Ft. Atkinson:
Gruesen, F. A.
Gueldner, L. H.
Hanson, O. H.
Harris, J. J.
Hunsader, H. N.
Mallow, H. G. E.
Notbohm, D. R.
Venning, J. R.
Young, Will

Fountain City:
Skemp, F. C.

Fox Lake:
Elliott, E. S.

Franksville:
Dockery, J. N.

Frederic:
Andrews, W. C.
Arveson, R. G.
Fischer, W. A.
Moore, R. M.

Fremont:
Arnoldussen, C. P.

Friendship:
Treadwell, G. F.

Galesville:
Alvarez, R. L.
Jegi, H. A.
Rohde, E. P.

Gays Mills:
Boyce, S. R.
Schott, O. J.

Genoa City:
McNeel, Laird

Gillett:
Bailey, D. M.
Berg, W. R.

Gilman:
Cramp, A. L.

Glenwood City:
Limberg, A. W.
Limberg, P. W.
McCusker, C. F.

Glidden:
Ansfield, F. J.

Goodman:
Maginn, R. J.

Grafton:
Pelant, K. F.

Grantsburg:
Hartzell, R. L.

Green Bay:
Atkinson, H. S.
Boersma, J. J.
Bolles, C. S.
Brusky, A. H.
Brusky, E. S.
Burdon, T. S.
Burns, Robert W.
Charbonneau, A. A.
Clark, E. V., Jr.
Cowles, R. L.
Denys, G. F.
Denys, K. J.
Dockry, P. F.
Dredge, T. J.
Dupont, A. J.
Ford, J. L.
Ford, W. W.
Frank, Herbert
Freedman, A. L.
Fuller, M. H.
Goelz, J. R.
Gosin, D. F.
Gosin, F. J.
Griggs, S. L.
Grossman, M. A.
Hagerty, W. T.
Halloin, J. E

Heitzman, H. H.
Hitch, O. M.
Icks, K. R.
Jensen, R. E.
Jordan, E. M.
Kane, Elizabeth D.
Kaufman, J. E.
Killeen, E. R.
Killins, J. A.
Killins, W. A.
Kispert, R. W.
Klobucar, J. J.
Kuehl, F. O.
Kuhs, M. L.
Kulkoski, Bernard
Leaper, W. E.
Levitas, I. E.
McCarey, A. J.
McDermott, J. F.
Miller, L. C.
Milson, Louis
Minahan, P. R.
Mokrohisky, S. M.
Nadeau, E. G.
Nadeau, E. George, Jr.
Neilen, J. W.
Neu, V. F.
Olmsted A. O.
Paine, E. M.
Quigley, L. D.
Robb, J. J.
Rose, R. J.
Rothe, C. A., Jr.
Saunders, O. W.
Schmidt, E. S.
Schmidt, R. T.
Shewalter, G. M.
Shinners, G. M.
Stauff, G. R.
Stiennon, O. A
Sullivan, Donel
Tippet, W. P.
Troup, R. L.
Troup, W. J.
Urban, Frank

Green Lake:
Leininger, A. T.

Greendale:
Brown, R. J.
Curtin, J. J.

Greenwood:
Olson, W. A.

Gresham:
Litzen, F. L.

Hales Corners:
Pierce, D. F.
Wolf, R. C.

Hartford:
Hoffmann, J. G
Hoffmann, W. C.
Lehmann, F. W.
Monroe, M. E.
Quackenbush, E. C.
Quandt, V. V.
Sachse, F. W.

Hartland:
Bergwall, R. P.
Hansen, R. T.
Ridley, J. F.
Samuelson, Clarence

Hayward:
Callaghan, D. H.
Krueger, E. R.
Wyant, M. E.

Hazel Green:
Rosmann, H. K.
Strauch, C. B.

Highland:
Erickson, M. T.

Hilbert:
Winkler, R. J.

Hillsboro:
Froehlke, T. P.
Leuther, P. A.
Sanford, L. L

Hixton:
Petzke, E. A.

Hollandale:
Marshall, S. B.

Horicon:
Karsten, J. H.
Knudson, R. A.

Hortonville:
Towne, W. H.

Hudson:
Anderson, M. G.
Bourget, G. E.
Cornwall, M. A.
Hopkins, G. J.
Livingstone, J. W.
Newton, J. E.
Nuebel, C. J.

Humbird:
Schwarz, S. G.

Hurley:
Bonacci, M. J.
Martinetti, D. J.

Hustisford:
Goetsch, O. F.

Independence:
Peterson, C. F.

Iola:
Haman, K. L.
Wiley, R. H.

Jackson:
Albrecht, J. E.

Janesville:
Baldwin, R. M.
Bartels, G. W.
Baumgartner, M. M.
Clark, W. T.
Danforth, H. C.
Dodge, R. K.
Donkle, M. J.
Farnsworth, R. W.
Frechette, F. M.
Freitag, S. A.
Gilbertsen, C. R.
Gutmann, G. E.
Hanlon, P. E.
Johnson, W. L.
Kelley, J. F.
Klein, T. W.
Koch, V. W.
Llewellyn, M. B.
McGuire, W. H.
Metcalf, G. S.
Munn, W. A.
Nuzum, T. O.
Nuzum, T. W.
Otterholt, E. R.
Overton, O. V.
Pember, A. H.
Pember, J. F.
Purdy, M. F.
Rau, Esther L.
Reinardy, A. L.
Reinardy, E. W.
Schroder, J. R.
Schroeder, J. D.
Snodgrass, H. M.
Snodgrass, T. J.
Steinkopff, E. K.
Tarrasch, Hertha
Thomas, G. L.
Tomlinson, Carol
Van Kirk, F. W.
Waufle, G. C.
Welch, F. B.

Jefferson:
Brewer, J. C.
Busse, A. A.
Caswell, H. O.
Garding, C. J.
Quandt, R. W.
Robinson, A. H

Johnson Creek:
Wendt, F. A

Junction City:
Reis, G. W.

Juneau:
Heath, H. J.

Kaukauna:
Bachhuber, A. E.
Bachhuber, A. M.
Behnke, G. A.
Boyd, G. L.
Cherkasky, Simon
Flanagan, G. J.
Russo, J. G.

Kenosha:
Andre, E. F.
Ashley, R. W.
Ashley, T. W.
Binnie, Helen A.
Block, R. M.
Bode, M. J.
Bowing, I. E.
Creighton, L. H.
Creswell, C. M.
Davin, C. C.
DeFazio, S. F.
Garrin, J. T.
Goldstein, D. N.
Graves, J. P.
Hill, B. Spaulding
Kappus, H. C.
Kent, L. T.
Kleinpell, W. C.
Kordecki, F. A.
La Macchia, R. M.
Lipman, W. H.
Lokvam, L. H.
Lutz, J. J.
Mayfield, A. L.
Morrow, C. A.
Olsman, Louis
Pearson, J. B.
Pechous, C. E.
Pechous, Lillian
Pifer, P. E.
Pirsch, Margaret V.
Powell, R. A.
Randall, A. J.
Rauch, A. M.
Rauen, L. M.
Richards, C. G.
Rufflo, A. F.
Sattler, C. A.
Schlapik, Alexander
Schulte, G. C.
Schwartz, G. J.
Schwartz, H. L.
Siegel, Morris
Stewart, W. C.
Swift, W. J.
Ulrich, C. F.
Weber, G. R.
Williams, F. C., Jr.

Kewaskum:
Edwards, R. G.

Kewaunee:
Nesemann, R. M.
Witcpalek, E. W.
Witcpalek, W. W.

Kiel:
Nauth, D. F.
Twohig, G. J.

Kimberly:
Maes, C. G.

King:
Hathaway, G. J.
Montgomery, R. C.

Kohler:
Gascoigne, C. C.
Heinz, H. N.

La Crosse:
Anderson, N. P.
Bach, A. C.
Beutler, T. V.
Bruder, V. F. J.
Buchman, D. M.
Carlsson, E. S.
Cook, A. A.
Daley, D. M.
Davies, May A.
Dietz, P. C.
Dixon, W. G.
Douglas, F. A.
Doyle, D. F.
Eagan, R. L.
Egan, G. J., Jr.
Egan, J. F.
Eidam, L. W.
Ernst, F. W.
Flynn, R. E.
Fox, J. C.
Gallagher, E. E.
Gallagher, F. J.
Gatterdam, P. C.
Gilbert, R. L.
Gorenstein, L. M.
Gray, R. H.
Gundersen, A. H.
Gundersen, Gunnar
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Gundersen, T. E.
Harman, J. C.
Harris, H. W.
Heraty, J. E.
Hulick, P. V.
Jones, W. J.
Kelly, C. M., Jr.
McGarty, M. A.
McNamara, T. B.
Midelfort, C. F.
Mueller, J. J.
O'Meara, M. T.
Parkin, E. M.
Perry, E. L.
Phillips, P. W.
Ramlow, R. W.
Reay, G. R.
Ridout, G. B.
Satory, J. J.
Schaefer, Margaret A.
Schmidt, L. R.
Schneeberger, E. J.
Sevenants, J. J.
Simones, J. J.
Sitterson, B. W.
Sivertson, Martin
Skemp, A. A.
Skemp, G. E.
Skemp, J. T.
Smith, D. S.
Swarthout, Edyth C.
Townsend, E. H.
Uhrich, G. I.
Wolf, F. H.

Ladysmith:
Bauer, W. B. A.
Lundmark, L. M.
Pagel, H. F.
Smith, Woodruff

La Farge:
Gollin, F. F.

Lake Geneva:
Bischof, H. F.
Brady, C. J.
Hudson, E. D.
Jeffers, D. H.
Sutch, Y. B.

Lake Mills:
Eck, G. E.
Leicht, Phillip
Liebenow, R. R.
Netzow, E. J.
Peterson, M. G
Schoenecker, E. A.
Turcott, R. A.

Lancaster:
Bauman, K. L.
Carey, H. W.
Fowler, J. H.
Houghton, E. M.
Kraut, Elgie

Land O'Lakes:
Eickhoff, E. C.

Laona:
Carroll, G. E.
Castaldo, E. F
Ovitz, E. G.

LaValle:
Booher, J. A.

Lena:
Rose, J. F.

Little Chute:
Curtin, D. W.
Verbrick, W. C.

Lodi:
Groves, R. J.
Irwin, W. G.

Loganville:
Jewell, E. L.

Lomira:
Fuller, J. D.

Loyal:
Hable, A. P.

Madison:
Aageson, C. W.
Albright, E. C.
Allin, R. N.
Anderson, A. D.
Angevine, D. M.
Ashman, H. C.
Atwood, D. C.
Baehr, L. T.
Barnes, M. E., Jr.
Becker, R. M.
Bell, P. P.
Benish, G. A.
Bennett, Maxine
Bentley, J. E.
Berger, J. V., Jr.
Bernard, F. D.
Betlach, Dorothy W.
Betlach, E. H.
Bleckwenn, W. J.
Boner, A. J.
Brindley, B. I.
Britton, D. M.
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Brown, J. W.
Bryan, A. W.
Burke, C. F.
Burke, Mead
Burke, Myra E.
Burns, E. M.
Burns, R. E.
Calvert, Charlotte
Cameron, Eugenia S.
Campbell, R. E.
Canfield, Albert
Carns, Marie L.
Carter, H. S.
Chase, S. L.
Clausen, N. M.
Collier, E. J.
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Curreri, A. R.
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Dawson, D. L.
Dean, F. K.
Dean, J. C.
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Dickie, Helen A.
Dieter, D. G.
Dimond, W. B.
Dollard, J. E.
Domine, A. Z.
Doolittle, J. W.
Duehr, P. A.
Erickson, T. C.
Ewell, G. H.
Farrell, R. X.
Fauerbach, Louis
Feig, Milton
Fike, F. A.
Filek, A. A.
Fitch, Edna M.
Fogelberg, Alma
Fogo, A. E.
Foseid, D. F.
Fosmark, C. A.
Foster, M. A.
Foster, Ruth C.
Fromm, A. H.
Gale, J. W.
Gallagher, J. T. F.
Ganser, W. J.
Garnett, G. M.
Gearhart, R. S.
Geppert, T. V.
Glover, B. H.
Golden, F. F.
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Gonce, J. E.
Gordon, E. S.
Green, R. E.
Greene, H. L.
Grimstad, Frances H.
Gross, T. A.
Grumke, E. H.
Guilford, H. M.
Hamel, M. O.
Hank, G. C.
Harmon, Doralea R.
Harper, C. S.
Harper, S. B.
Harris, J. W.
Healy, W. G.
Hennen, R. J.
Hibma, O. V.
Hilger, W. A.
Hill, N. A.
Hobbins, W. B.
Hodgson, E. R.
Hogan, L. H.
Holmgren, L. E.
Hummer, F. L.
Hunter, Amy Louise
Hurlbut, J. A.
Iams, A. M.
Jackson, A. S.
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Jaeschke, W. H.
Jarvis, E. C.
Joachim, F. G.
Johnson, H. C.
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Jones, F. S.
Jorris, E. H.
Juhl, J. H.
Juster, E. M.
Kabler, J. D.
Kamholz, J. H.
Kant, Fritz
Kay, H. M.
Kincaid, C. K.
Kolman, I. E.
Krehl, W. H.
Kundert, P. R.
Kurtz, C. M.
Kurtz, Esther C.
Lacke, C. L.
Laird, Anna K.
Land, J. F.
Larson, F. C.
Lawrence, P. J.
Lemmer, K. E.
Leonard, T. A.
Lewis, R. F., Jr.
Lewis, W. C.
Lindsay, W. T.
Littig, L. V.
Longley, B. J.
Lorenz, T. H.
Lorenz, W. F.
Ludden, R. H.
Luetke, W. V.
Mac Kay, A. M.
Mailer, A. R.
Malec, J. P.
Maloney, F. G.
Maloof, G. J.
Marsden, W. H.
Masten, Mabel G.
McCormick, S. A.
McDonough, K. B.
McGary, Lester
McIllece, Patricia E.
McIntosh, R. L.
Meanwell, W. E.
Mehnert, J. H.
Mendenhall, J. T.
Meyer, O. O.
Middleton, W. S.
Miller, J. E.
Mohs, F. E.
Moore, J. C.
Mueller, J. J.
Musser, M. J., Jr.
Nause, F. P.
Nelson, P. D.
Nereim, T. J.
Nesbit, M. E.
Nesbit, W. M.
Neupert, C. N.
Newman, J. R.
Nordby, E. J.
Nugent, M. E.
Oakley, Dorothy H.
Okagaki, H. I.
Olson, D. E.
Oosterhous, G. E.
Orth, O. S.
Osborn, L. A.
Owen, Otto
Parkin, R. C.
Parks, H. K.
Paul, L. W.
Paulson, J. F.
Peabody, C. S.
Peters, H. A.
Pohle, E. A.
Prouty, Margaret
Puestow, K. L.
Quinn, R. W.
Quisling, A. A.
Quisling, R. A.
Quisling, Sverre
Ragaz, F. J. B.
Rasmussen, A. F., Jr.
Reese, H. H.
Reis, L. M.
Reznichek, C. G.
Rhoades, A. L.
Richards, J. N.
Richtsmeier, A. J.
Ris, Hania W.
Roemer, E. P.
Roessler, R. L.
Rogers, S. C.
Rotter, Royal
Salick, J. A.
Sarfatty, I. J.
Schafer, Etheldred L.
Schilling, R. F.
Schlenker, G. M.
Schmidt, E. R.
Schmitz, R. C.
Schneiders, E. F.
Schoenenberger, A. P.
Schubert, C. K.
Schuele, D. T.
Schwittay, Addie M.
Settlage, P. H.
Shapiro, H. H.
Sherman, C. F.
Shumate, J. K.
Siebecker, K. L.
Sims, J. L.
Sinaiko, R. P.
Sisk, I. R.
Skroch, E. E.
Smith, M. M.
Smith, R. M.
Soucek, Adolph
Sprague, J. T.
Sprague, L. V.
Stebbins, G. G.
Stebbins, W. W.
Steeper, J. R.
Stehr, A. C.
Steinhaus, J. E.
Stewart, Katherine E.
Stiennon, O. A.
Stone, Mildred M.
Stoops, C. W.
Stovall, W. D.
Straughn, R. A.
Suckle, H. M.
Sullivan, A. G.
Sullivan, E. S.
Supernaw, J. S.
Taborsky, C. R.
Talbot, J. R.
Tanner, W. A.
Tatum, A. L.
Taylor, F. B.
Tenney, H. K.
Tenney, H. K., III
Thornton, Madeline J.
Tormey, A. R.
Tormey, T. W.
Trautmann, Henry
Triggs, P. O.
Tweeten, J. K.
Urben, W. J.
Van Buser, A. L.
Van Gemert, J. G.
Vingom, C. O.
Vinograd, S. P.
Waddell, J. G.
Ware, R. H.
Washburne, Annette C.
Waskow, W. L.
Wasserburger, R. H.
Waters, D. D.
Wear, J. B.
Weinstein, A. B.
Welke, E. G.
Wepfer, J. F.
Werrell, W. A.
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White, D. H.
Wilkie, J. M.
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Wirig, M. H.
Wirka, H. W.
Wixson, R. C.
Worley, Gordon
Wylde, R. M.
Young, W. P.

Manawa:
Irvine, R. K.

Manitowoc:
Andrews, M. P.
Belson, H. J.
Bonner, N. A.
Donohue, W. E.
Erdmann, N. C.
Gregory, L. W.
Hammond, F. W.
Hammond, R. W.
Hoffman, G. M.
Lynch, J. D.
O'Neill, C. J.
Pick, D. M.
Radl, C. J.
Randolph, R. C.
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Rau, G. A.
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Rees, T. H.
Schaefer, H. E.
Scherping, W. H.
Simenson, R. S.
Simon, G. M.
Sobush, L. D.
Steckbauer, J. W.
Strong, R. G.
Stueck, A. F.
Teitgen, Arthur
Teitgen, T. A.
Thorpe, R. F.
Wall, C. E.
Yost, R. G.
Zibel, Milton

Marathon:
Kampine, C. E.

Maribel:
May, J. H.

Marinette:
Boren, C. H.
Boren, Clark H.
Boren, J. A.
Boren, J. W., Jr.
Duer, G. R.
Jorgenson, H. L.
Kirmse, T. W.
Koepp, C. E.
May, J. V.
McCanna, P. R.
Moss, K. J.
Nadeau, A. T.
Pinegar, K. G.
Schroeder, H. F.
Shaw, R. W.
Zeratsky, J. D.

Marion:
Van Schaick, R. E.

Markesan:
Cupery, D. P.
Pelton, R. S.

Marshfield:
Baldwin, Elizabeth
Baldwin, R. S.
Boeckman, F. A.
Custer, G. S., Jr.
Doege, K. H.
Doege, P. F.
Epstein, Stephan
Gouze, F. J.
Helland, N. J.
Mason, R. W.
McCormick, G. L.
Miale, J. B.
Millard, A. L.
Potter, R. P.
Rice, T. J.

Rowe, R. J.
Vedder, C. A.
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Wierzbinski, F. A.
Wink, R. H.

Mauston:
Griffin, V. M.
Hess, J. S.
Tverberg, M. S.
Vedner, J. H.

Mayville:
Bachhuber, F. G.
Parish, G. A.
Royce, M. E.

Mazomanie:
Schultz, Isadore

Medford:
Elvis, E. B.
Meyer, W. W.
Nystrum, L. E.
Nystrum, R. C.

Mellen:
Lockhart, C. W.

Melrose:
Lavine, I. H.

Menasha:
Conway, J. E.
Corry, L. F.
Forkin, G. E.
Hildebrand, G. B.
Hildebrand, W. B.
Jensen, F. G.
Jensen, R. A.
Nebel, J. R.
O'Brien, P. T.
Pratt, G. N., Jr.
Schwei, G. P.

Menomonee Falls:
Baugh, C. W.
Burkhardt, E. W.
Domann, W. G.
Hoyt, G. E.
Schloemer, A. J
Schloemer, H. F.

Menomonie:
Buckley, C. H.
Cook, F. D.
Drescher, A. A.
Grannis, I. V.
Halgren J. A.
Lee, S. R.
Lumsden, Wm
McMahon, A. E.
Mann, G. A.
O'Neill, J. W.
Quilling, P. A.
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Mercer:
Ashe, H. S.
Kleinboehl, J. W.

Merrill:
Bayer, L. J.
Bayer, W. H.
Kelley, F. H.
Lane, F. C.
Lewinnek, Walter
Millenbah, J. D.
Morris, K. A.
Ravn, Bjarne
Ravn, E. O.

Middleton:
Stricker, M. F.

Milltown:
Hohf, A. H.

Milton:
Burdick, H. L.
Crosley, G. E.
Davis, M. D.

Milton Junction:
Holmes, J. F.
Vogel, T. L.

Milwaukee:
Ackerman, J. S.
Ackermann, Wm.
Adamkiewicz, J. J.
Aguirre, M. R.
Allen, L. L.
Altmeyer, J. R.
Anderson, W. A. D.
Ansfield, D. J.
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Apfelberg, H. J.
Appleby, K. B.
Armbruster, J. L.
Arneth, J. J.
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Axelrod, Sidney
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Babbitt, D. P.
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Backus, E. A.
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Balistreri, Frank
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Baumgart, C. H.
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Bechmann, Fred
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Beckman, Harry
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Belfus, F. H.
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Bellehumeur, C. E.
Bemis, E. L.
Bender, B. I.
Benjamin, H. B.
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Bercey, J. E.
Bergmann, G. J.
Berner, C. L.
Bernhard, L. A.
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Beutler, A. D.
Bickler, E. P.
Bielefeld, Mary E.
Biller, J. H.
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Birge, E. A.
Black, S. B.
Blanchard, H. H.
Blankstein, S. S.
Blount, W. P.
Blumenthal, R. W.
Bodden, A. M
Bolger, J. Victor
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Bookhamer, J. W.
Borman, M. C.
Bornstein, Max
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Bortin, M. M.
Bourne, N. W.
Boxer, L. M.
Boxer, S. M.
Brah, W. A.
Brewer, B. J.
Brey, P. F.
Brillman, C. R.
Broadbent, Mary
Brook, J. J.
Brown, R. C.
Brunkhorst, R. O.
Bruns, D. H.
Brzezinski, E. A.
Budny, C. L.
Bunkfeldt, Frederick
Burden, J. G.
Busby, W. W.
Buscaglia, A. T.
Buscaglia, C. J.
Buscklewicz, T. S.
Bussey, A. D.
Byrne, R. W.
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Cahana, Stephen
Callan, P. L.
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Cannon, H. J.
Carl, E. E.
Carl, E. F.
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Cervenansky, A. A.
Chambers, R. K.
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Chapman, B. L.
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Chase, Jules
Chojnacki, S. L.
Churchill, B. P.
Clasen, W. E.
Claudon, D. B.
Cleveland, Davld
Coffey, S. E.
Coffey, W. L., Jr.
Coheen, J. J.
Collentine, G. E.
Collentine, G. E., Jr.
Collopy, P. J.
Conen, W. J.
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Conroy, C. F.
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Cralte, E. J.
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Cron, R. S.
Crottler, C. J.
Currer, P. R.
Curtin, A. L.
Curtis, W. C.
Dall, G. A.
Dallwig, E. L.
Dallwig, H. C.
Danaher, H. H.
Darling, F. E., Sr.
Darling, F. E., Jr.
Darling, S. J.
Davidoff, I. Z.
Davies, J. A., Jr.
Dean, G. W.
Decker, H. G.
Dedinsky, G. A.
Demeter, N. D.
Derse, F. R.
Devitt, J. S.
Diamond, C. O.
Dishmaker, M. C.
Dix, C. R.
Dorn, A. S.
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Drew, F. E.
Dricken, H. N.
Drischler, W. H.
Drozewski, M. F.
Duffy, H. R.
Dundon, J. R.
Dunker, G. O.
Dunn, E. T.
Dunst, C. G.
Dvorak, H. J.
Eberbach, C. W.
Eby, L. G.
Edelman, Elsa B.
Egan, W. J.
Eichenberger, C. R.
Eisenberg, E. E.
Eisenberg, L. A.
Eisenberg, P. J.
Elconin, D. V.
End, E. M.
End, J. A.
Enright, J. A.
Enzer, Norbert
Epperson, P. S.
Epstein, Eli
Erbes, John
Evans, S. M.
Evrard, J. R.
Faber, C. A.
Fabric, B. L.
Falsetti, F. F.
Fant, J. R.
Farrell, H. J.
Fechter, F. J.
Fechter, F. R.
Feiman, L. H.
Feld, S. M.
Feldman, E. I.
Fellman, G. H.
Fetherston, J. P.
Fetherston, J. P., Jr.
Fetherston, W. C.
Feurig, J. S.
Fidler, Charles
Finn, C. J.
Fisher, L. M.
Fitzgerald, G. F.
Fitzgerald, R. E.
Fitzsimmons, Antoinette V.
Fleischmann, J. A.
Fletcher, H. A.
Flood, R. E.
Flynn, R. T.
Foerster, F. E.
Foerster, H. R.
Foerster, O. H.
Foley, L. J.
Foley, T. J.
Fons, J. W.
Foregger, Richard
Fortier, C. A. H.
Fox, M. J.
Fox, M. S.
Frackelton, W. H.
Franklin, Emil
Franklin, Isadore
Franklin, S. N.
Frawley, D. D.
Freedman, M. S.
Frey, P. G.
Frisch, R. A.
Froede, H. E.
Froelich, J. A.
Gabor, M. E.
Gaenslen, F. G.
Galasinski, R. E.
Gallimore, R. G.
Garens, R. W.
Garland, J. G.
Garner, L. L.
Garvey, J. L.
Gaspich, R. J.
Gatherum, D. H.
Gaunt, J. J.
Gaynon, I. E.
Gebert, W. H.
Gebhard, U. E.
Gecht, E. A.
Geiger, Sara G.
Gendlin, N. A.
Gertenbach, E. O.
Gilbert, Joseph
Gilchrist, R. T.
Gingrass, R. P
Glasson, L. G. G.
Glisch, W. P.
Goldberg, Nat.
Goldberger, Esther W.
Goodman, J. A.
Goodman, J. S.
Goodman, P. P.
Goodsitt, A. H.
Gorder, A. C.
Gordon, N. F.
Gorens, S. W.
Gorenstein, Leonard
Gramling, J. J.
Gramling, J. J., Jr.
Greenberg, A. I.
Greenberg, Maurice
Greenwalt, T. J.
Griffith, J. C.
Grob, A. R. F.
Grossman, N. M.
Grossmann, E. E.
Grotjan, W. F
Gruender, J. E.
Guardalebene, Vito
Gudex, V. A.
Guerin, L. H.
Gumerman, G. J.
Gute, E. B.
Gutglass, M. J.
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Hake, C. B.
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Halser, J. G.
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Hansen, H. T.
Hansen, J. W.
Hansher, Ervin
Hanson, E. R.
Hanson, R. A.
Hara, Kinge
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Hardgrove, Maurice
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Haug, J. F.
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Karen, Robert
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Kohler, S. H.
Kohn, A. M.
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Korducki, S. A.
Kores, Vernon
Kovacs, Arthur
Kozina, F. J.
Kozina, V. J.
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Kramoris, F. H.
Kreissl, L. J., Jr.
Krembs, M. A.
Kretchmar, J. S.
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Kretlow, F. A.
Kreuter, G. C.
Kristjanson, H. T.
Kritter, F. J.
Kriz-Hettwer, Rose
Krueger, Bernard
Krueger, F. J.
Krumbiegel, E. R.
Kruszewski, J. L.
Krygier, A. A.
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Krzysko, S. L.
Kuehn, Eleanor V.
Kuhn, H. J.
Kuhn, M. J.
Kult, A. S.
Kustermann, A. F.
Kwapy, C. R.
La Bissoniere, P. G.
Lademan, O. E.
Ladewig, A. W.
Ladewig, H. C.
Lando, D. H., Sr.
Lando, D. H., Jr.
Lang, V. F.
Langjahr, A. R.
La Susa, T. J.
Lawhorn, C. C.
LeCron, W. L.
Lee, H. J.
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Lehman, R. H.
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Le Tellier, M. S.
Lettenberger, Joseph
Levin, A. J.
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Light, George
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Lindert, M. C. F.
Lipscomb, T. C.
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Long, C. W.
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McBeath, N. E.
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McLaughlin, B. C.
McMahon, F. B.
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McNamara, L. V.
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Megna, Salvatore
Meisinger, G. F.
Melamed, Abraham
Mellencamp, F. J.
Meloy, G. E.
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Mensing, E. H.
Merdinger, W. F., Jr.
Merten, A. N. E.
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Messmer, Clemens
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Mikolajezak, N. A.
Millen, F. J.
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Miner, D. L.
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Minton, Richard
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Mookerjee, M. K.
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Mountain, D. C.
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Mufson, J. A.
Multhauf, C. J.
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Muskat, Irving
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Neacy, C. F.
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O'Leary, E. B.
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O'Neill, E. J.
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Paegel, H. A., Jr.
Pallasch, F. J.
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Paulbeck, T. M.
Pedersen, Elaine K.
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Pessin, S. B.
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Pink, J. J.
Pleyte, A. A.
Pohle, H. W.
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Polka, M. G.
Pollack, S. K.
Popp, Albert
Powers, H. W.
Presti, A. A.
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Punto, F. J.
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Purvis, R. F.
Quick, A. J.
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Ramlow, L. W.
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Reath, R. R.
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Rose, Mona
Rosenbaum, F. F.
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Rosenthal, Samuel
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Royce, Owen, Jr.
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Schelble, E. J.
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Schreiber, Manuel
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Slutzky, Nathan
Smigielski, K. M.
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Treskow, F. G.
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Tuchscherer, Mabel E.
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Wong, V. J.
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Wyland, J. S.
Wyman, J. F.
Wynn, S. K.
Yaffe, Aaron
Young, A. F.
Yunck, R. E.
Zaun, J. J., Jr.
Zawodny, S. E.
Zeier, F. G.
Ziegler, C. T.
Zillmer, Helen J.
Zimmermann, B. M.
Zmyslony, W. P.
Zubatsky, D. J.
Zurheide, H. O.

Mineral Point:
Hohler, E. J.
Ludden, H. D.
Ridley, S. R.
White, C. L.

Minocqua:
Huber, G. W.
Savory, P. B.
Sprague, J. P.

Mishicot:
Skwor, C. J.

Mondovi:
Gillette, F. J.
Johnson, B. F.
Meyer, C. F.
Sharp, D. S.
Swanson, R. F.
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Monroe:
Barry, G. R.
Baumle, C. E.
Bear, N. E.
Bear, W. G.
Blum, O. S.
Brunkow, B. H
Eckstam, E. E.
Fencil, W. J.
Gnagi, W. B., Jr.
Kindschi, L. G.
Kundert, F. W.
Leiser, A. E.
Mings, D. E
Moore, L. A.
Peters, E. E.
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Weir, J. R.

Montello:
Federman, E. H.
Inman, R. F.

Montfort:
Rasmussen, N. G.

Monticello:
Benkendorf, Charles

Montreal:
Baird, H. D.
Pierpont, J. M.

Mosinee:
Hoessel, A. W.
Knoedler, W. A., Jr.

Mount Calvary:
Curry, J. C.
Miller, J. F.

Mount Horeb:
Buckner, H. M.
Morrison, M. T.

Mukwonago:
Kern, E. E.
Voellings, W. J.

Muscoda:
Ackerman, E. T.
Klockow, W. E.

Muskego:
Kelm, G. J.
Krill, R. J.

Neenah:
Anderson, G. R.
Beglinger, H. F.
Brown, R. C.
Brunckhorst, F. O.
Canavan, J. P.
Graham, A. P.
Henning, Laura E.
Henning, R. E.
Kirchgeorg, Clemens
Pansch, F. N.
Petersen, G. W.
Pitz, M. N.
Quade, R. H.
Regan, D. M.
Smith, F. H.
Smith, Robin
Smith, T. D.
Springer, V. G.
Strauser, E. R.

Neillsville:
Frank, H. A.
Manz, K. F.
Overman, M. V.
Rosekrans, M. C.
Rosekrans, Sarah D.

Nekoosa:
Pomainville, H. G.
Werner, W. A.

Neopit:
Erdlitz, F. J.

New Auburn:
Stang, H. M.

Newburg:
Salter, R. K.

New Franken:
Looze, J. A.

New Glarus:
Francois, S. J. A.
Hicks, E. V.

New Holstein:
Engel, A. C.
Larme, F. P.

New Lisbon:
Starnes, Brand

New London:
Borchardt, M. A.
Dernbach, G. P.
Monsted, J. W.
Pfeifer, F. J.
Schmallenberg, H. C.

New Richmond:
Armstrong, J. H.
Davis, R. R.
Drury, E. M.
Epley, O. H.
Healy, J. P.

Niagara:
Lamb, R. F.
McCormack, E. A.

North Lake:
Donnelly, F. J.

Norwalk:
Allen, J. S.

Oconomowoc:
Clark, O. C.
Feasler, C. H.

James, W. D.
Lohrman, G. H.
Loughnan, A. J.
Love, G. R.
Nammacher, T. H.
Rogers, A. F.
Stemper, Irene T.
Theobald, P. B.
Wilkinson, D. C.
Wilkinson, J. D.
Wilkinson, J. F.
Wilkinson, M. R.
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Oconto:
Aageson, H. A.
Mohler, G. T.
Rogers, R. J.
Slaney, A. F.
Zantow, F. E.

Oconto Falls:
Goggins, R. J.
Rauchschwalbe, L. E.
Robinson, T. N.

Ogema:
Rinehart, B. M.

Omro:
Peck, D. D.
Schoenbechler, L. J.

Onalaska:
Reay, G. D.

Oneida:
Minoka-Hill, Lillie R.

Ontario:
Devine, G. C.

Oregon:
Dukerschein, F. N.
Johnson, E. S.
Kellogg, L. S.

Orfordville:
McNair, E. R.

Osceola:
Simenstad, L. O.
Weller, L. J.

Oshkosh:
Beatty, S. R.
Behnke, C. H.
Bitter, R. H.
Clark, W. E.
Connell, F. G.
Cummings, E. F.
Danforth, H. J.
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Emrich, P. S.
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Graiewski, S. J.
Greenwood, Ben. S.
Guenther, V. G.
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Kronzer, J. J.
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Meilicke, C. A.
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Steen, M. H.
Wagner, R. F.
Wagner, W. A.
Wheeler, W. P.
Williams, E. B.
Winter, E. F.
Wood, H. W., Jr.

Osseo:
Knutson, Oscar
Leasum, R. N.

Oxford:
Nafzeger, E. G.

Palmyra:
Handeyside, R. G.

Pardeeville:
Gillette, H. E.
Winkler, H. A.

Park Falls:
Leahy, J. D.
Leahy, J. J.
Murphy, J. L.

Pepin:
Belitz, A. E.
Hogan, John

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Bell, J. M.
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Haasl, H. W.

Pewaukee:
Egloff, L. W.
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Phelps:
Schmitt, R. W.

Phillips:
Niebauer, W. E.
Norviel, H. B.
Rens, J. L.
Van Hecke, D. S.

Platteville:
Andrew, C. H.
Bair, G. W.
Conklin, J. W.
Cunningham, Wilson
Doeringsfeld, H. L.
Moffett, J. L.
Soles, F. A.
Wheeler, C. H. E.

Plum City:
Steiger, E. E.

Plymouth:
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Eisen, H. L. ---------- University, Missouri
Ellinger, A. J. ---------- Willmar, Minnesota
Everett, H. H., Jr. ---------- Ventura, California

Fitzgerald, G. P. ---------- Indianapolis, Indiana
Fox, G. E. ---------- Washington, D. C.

Grant, L. C., Jr. ---------- New York City, New York
Gulbrandsen, Halbert ---------- Denver, Colorado

Hackbarth, D. E. ---------- New York City, New York
Haley, H. B. ---------- Boston, Massachusetts
Hartson, R. C. ---------- Worcester, Massachusetts
Haseltine, C. P. ---------- New York City, New York
Hayworth, Ballard ---------- Topeka, Kansas
Heen, R. C. ---------- Menlo Park, California
Henry, E. W. ---------- Camarillo, California
Hoffmann, G. T. ---------- Philadelphia, Pennsylvania
Horwitz, Emanuel ---------- West Roxbury, Massachusetts
Hoyme, Gjermund ---------- Coronado, California

Irwin, H. J. ---------- Pecatonica, Illinois

Jacks, R. R. ---------- Menard, Illinois
Johnson, R. D. ---------- Ypsilanti, Michigan
Johnson, R. O. ---------- Bottineau, North Dakota
Jones, W. L. ---------- Sioux Falls, South Dakota

Kagan, Louis ---------- New York City, New York
Kelly, W. J. ---------- Denver, Colorado
Kline, C. L. ---------- Mesa, Arizona
Klotz, A. P. ---------- LaGrange, Illinois
Kohler, H. H. ---------- Cincinnati, Ohio
Koon, W. D. ---------- Redwood City, California
Kukral, A. J. ---------- Salt Lake City, Utah

Lamal, A. H. ---------- Waterford City, North Dakota
Lehner, R. H. ---------- Bala-Cynwyd, Pennsylvania
Lorenz, T. H. ---------- New York City, New York
Lukes, R. E. ---------- Washington, D. C.

McCormick, G. E. ---------- Redwood City, California
McJilton, C. E. J. ---------- Fort Harrison, Montana
MacCollum, C. L. R. ---------- Fort Lauderdale, Florida
Malloy, T. G. ---------- Little Rock, Arkansas
Mansheim, B. J. ---------- Iowa City, Iowa
Mathewson, R. C. ---------- Boston, Massachusetts
Matt, J. R. ---------- Urbana, Illinois
Matthiesen, D. E. ---------- Memphis, Tennessee
Mendez, A. A. ---------- New York City, New York
Meyer, B. J. ---------- Santa Monica, California
Mudge, W. A., Jr. ---------- Hines, Illinois
Mullen, R. A. ---------- Tampa, Florida
Muscato, G. V., Jr. ---------- Lockport, New York

Nicolai, C. H. ---------- St. Louis, Missouri
Nissenbaum, James ---------- Philadelphia, Pennsylvania

O'Donnell, Mae J. ---------- Wadsworth, Kansas
Olson, H. J. ---------- Los Angeles, California

Pisciotta, A. V. ---------- Boston, Massachusetts

Quinlivan, J. K. ---------- Buffalo, New York

Richards, R. A. ---------- Balwin, Long Island, New York
Roisum, B. H. ---------- Oak Ridge, Tennessee

Schubert, E. F. ---------- Logansport, Indiana
Seeger, S. J. ---------- Dallas, Texas
Shimpa, J. F. ---------- Cheyenne, Wyoming
Sims, A. M. ---------- Encino, California
Smith, M. B. ---------- Minot, North Dakota
Sundquist, G. V. ---------- Cheyenne, Wyoming

Thorngate, George III ---------- Alfred, New York

Van Riper, H. E. ---------- New York City, New York

Wallner, Alfred ---------- Long Beach, California
Walske, B. R. ---------- Lincoln, Nebraska
Warrick, J. D. ---------- Camarillo, California
Waters, R. M. ---------- Orlando, Florida
Wells, May R. ---------- Belleville, Illinois
Wenstrand, D. E. W. ---------- Tryon, North Carolina
West, R. C. ---------- San Rafael, California
Wilson, N. M. ---------- Elmhurst, Illinois
Wochos, R. G. ---------- San Luis Obispo, California
Woelfel, G. F. ---------- Huntington, West Virginia

Life Members of State Medical Society

Allen, W. J. ---------- Beloit

Barnes, J. S. ---------- Milwaukee
Beebe, L. W. ---------- Superior
Beebe, S. D. ---------- Sparta
Belitz, A. E. ---------- Pepin
Bolton, E. L. ---------- Appleton
Brehm, H. J. ---------- Racine
Brooks, E. H. ---------- Bloomington
Brunckhorst, F. O. ---------- Neenah

Cairns, R. U. ---------- River Falls
Campbell, W. B. ---------- Waukesha
Caswell, H. O. ---------- Jefferson
Connell, F. Gregory ---------- Oshkosh
Crockett, W. W. ---------- Beloit
Crosby, E. P. ---------- Stevens Point
Cunningham, Wilson ---------- Platteville

Donohue, M. J. ---------- Antigo

Fazen, L. E. ---------- Racine
Folsom, W. H. ---------- Fond du Lac
Forkin, G. E. ---------- Menasha
Friend, L. J. ---------- Beloit

Gavin, S. E. ---------- Fond du Lac
Goggins, R. J. ---------- Oconto Falls
Grosskopf, E. C. ---------- Waukesha

Hammond, F. W. ---------- Manitowoc
Hardgrove, J. H. ---------- Shawano

Haubrick, H. J. ---------- Oshkosh
Haushalter, H. P. ---------- Milwaukee
Hipke, G. A. ---------- Milwaukee
Irwin, H. J. ---------- Pecatonica, Illinois
Jackson, J. A. ---------- Wausau
Junck, J. A. ---------- Sheboygan
Leonard, C. W. ---------- Fond du Lac
Linn, W. N. ---------- Oshkosh
Lockhart, C. W. ---------- Mellen
Lockhart, J. W. ---------- Oshkosh
Ludden, H. D. ---------- Mineral Point
Lumsden, William ---------- Menomonie
Lundmark, L. M. ---------- Ladysmith
Maes, C. G. ---------- Kimberly
Malone, F. A. ---------- Waterford
Marshall, V. F. ---------- Appleton
Meusel, H. H. ---------- Oshkosh
Munn, W. A. ---------- Janesville
Nadeau, A. T. ---------- Marinette
Notbohm, W. R. ---------- Dousman
Nuzum, T. W. ---------- Janesville
Olmsted, A. O. ---------- Green Bay
Peehn, F. G. ---------- Sturtevant
Perrin, H. E. ---------- Star Prairie
Peterson, C. F. ---------- Independence
Petzke, E. A. ---------- Hixton
Pomainville, F. X. ---------- Wisconsin Rapids
Pope, F. W. ---------- Racine
Quick, E. W. ---------- Milwaukee
Radloff, A. C. ---------- Plymouth
Raymond, R. G. ---------- Brownsville
Reeve, J. S. ---------- Appleton
Schein, J. E. ---------- Oshkosh
Schmidt, E. S. ---------- Green Bay
Schroeder, H. F. ---------- Marinette
Smith, J. F. ---------- Wausau
Smith, S. M. B. ---------- Wausau
Tasche, C. T. ---------- Sheboygan
Thomas, W. O. ---------- Clinton
Twohig, D. J. ---------- Fond du Lac
Webb, E. P. ---------- Beaver Dam
Wheeler, W. P. ---------- Oshkosh
Wilkinson, M. R. ---------- Oconomowoc
Witcpalek, W. W. ---------- Kewaunee
Young, A. F. ---------- Milwaukee

Honorary Members of County and State Societies

Bradley, H. C. ---------- Madison
Clark, P. F. ---------- Madison
McCracken, R. W. ---------- Union Grove
Meek, W. J. ---------- Madison
Minoka-Hill, Lillie R. ---------- Oneida
Pusey, W. A. ---------- Chicago, Illinois
Sisk, I. R. ---------- Madison
Sullivan, W. E. ---------- Madison
Taylor, J. Gurney ---------- Milwaukee

POSTMORTEM EXAMINATION

A great deal of confusion has always existed about whose consent is required to permit a physician to conduct a postmortem examination with impunity. Sometimes the next of kin was not immediately available, or there were several persons of the same degree of kinship. The physician who performed such an examination without proper written consent did so at considerable personal risk.

Now, under the law, consent for a physician to conduct a postmortem examination is sufficient when given by the person who assumes custody of the body for burial, providing he is the father, mother, husband, wife, child, guardian, or next of kin. If none of these are available, consent may be given by a friend or person charged by law with responsibility for burial. If two or more such persons assume custody of the body, the consent of either one is sufficient.

CHICAGO MEDICAL SOCIETY WILL PRESENT CLINICAL CONFERENCE

The Clinical conference which has been established by the Chicago Medical Society for presentation each spring, offers lectures on many aspects of medicine to keep doctors abreast of the new things being developed from year to year. Each year the Society presents something of special interest to those attending. It will be held March 4, 5, 6, 7, 1952 in the Palmer House, Chicago.

This conference will feature a large number of demonstrations or work shop periods in addition to the regular series of lectures. These demonstrations will include presentation of patients, selected scientific movies, and other features interesting from an educational standpoint. The lectures are on subjects of interest to both the general practitioner and the specialist and will be one half hour in duration. The faculty will represent outstanding teachers of the medical world.

Charter Law of Medical Societies in Wisconsin

Chapter 148

148.01 (1) State society. The state medical society of Wisconsin is continued with the general powers of a corporation. It may from time to time adopt, alter and enforce constitution, by-laws and regulations for admission and expulsion of members, election of officers, and management.

(2) A member expelled from a county medical society may appeal to the state society, whose decision shall be final.

(3) (a) The state society, or a county society in manner approved by the state society, shall have the power to establish in the state or in any county or counties therein, a nonprofit plan or plans for the sickness care of indigents and low income groups, and others, through contracts with public officials, and with physicians and others, and by the use of contributions, cooperative funds, and other means, provided only that free choice of physicians within such contracts shall be retained and that responsibility of physicians to patient and all other contract and tort relationships with patient shall remain as though the dealings were direct between physician and patient. Any person covered by or insured under such plan shall be free to choose for sickness care any medical or osteopathic physician, licensed to practice in Wisconsin who has agreed to abide by such plan according to its terms and no such physician or osteopath shall be required to participate exclusively in any such plan.

(b) Such plan shall be exempt from the state insurance laws except those provisions relating to nondiscriminatory rates contained in section 201.53, investments contained in section 201.25 and premium reserves contained in section 201.18 (1).

(c) The society shall file with the commissioner of insurance a written declaration defining the organization and structure of the proposed sickness care plan and its area of operations and shall file any amendments or changes thereto. There shall also be filed with the commissioner specimen copies of all contracts with the insured and with the participating physicians and surgeons and the form of such contracts must be approved by the commissioner.

(d) The provisions of section 148.01 (3) (c) shall not apply to any plan nor to any revisions thereof in existence on the effective date of this paragraph, nor to any contracts for the care of the indigent, nor shall any provision of chapter 148 be construed to apply to any corporation, association or organization not a body corporate under said chapter.

148.02 (1) County societies. The physicians and surgeons, not less than five in number, of the several counties, except those wherein a county medical society exists may meet at such time and place at the county seat as a majority agree upon and organize a county medical society, and when so organized it shall be a body corporate by the name of the medical society of such county, shall have the general powers of a corporation, and may take by purchase or gift and hold real and personal property. County medical societies now existing are continued with the powers and privileges conferred by this chapter.

(2) Physicians and surgeons who, before April 20, 1897, received a diploma from an incorporated medical college or society of any of the United States or territories or of any foreign country, or who shall have received a license from the state board of medical examiners, shall be entitled to meet for organization or become members of the county medical society.

(3) If there be not a sufficient number of physicians and surgeons in any county to form a medical society they may associate with those of adjoining counties, and the physicians and surgeons of not more than fifteen adjoining counties may organize a medical society under this chapter, meeting at such time and place as a majority agree upon.

(4) A county medical society may from time to time adopt, alter and enforce constitution, by-laws and regulations for the admission and expulsion of members, election of officers, and management, not inconsistent with the constitution, by-laws and regulations of the state society.

1841—THE SOCIETY CREATED BY TERRITORIAL LEGISLATION

The first statutory recognition of the State Medical Society was by act of the Legislative Assembly of the Territory of Wisconsin, in Act 53 of the Territorial Legislature of 1841. The organization of the Society was authorized, with the declaration that ". . . well regulated medical societies have been found to contribute to the advancement and diffusion of true science, and particularly of the healing art. . ."

The organization meeting was set for the second Monday in January, 1842, at Madison, for the purpose of forming ". . . a society under the name and style of the Medical Society of the Territory of Wisconsin. . ." Drs. Bushnell B. Cary, M. C. Darling, Lucius I. Barber, Oliver E. Strong, Edward McSherry, E. W. Wolcott, J. C. Mills, David Walker, Horace White, Jonas P. Russell, David Ward, Jesse S. Hewett, B. O. Miller, and their associates, were authorized by statute to conduct the initial organization of the Society.

Constitution and By-Laws of the State Medical Society of Wisconsin*

CONSTITUTION

ARTICLE I

NAME OF THE ASSOCIATION

The name and title of this organization shall be the State Medical Society of Wisconsin.

ARTICLE II

PURPOSE

The purposes of this Society shall be to federate and bring into one compact organization the entire medical profession of the State of Wisconsin, and to unite with similar societies of other states and territories of the United States to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education, and to secure the enactment and enforcement of just medical laws; to promote friendly intercourse among physicians; and to enlighten and direct public opinion in regard to the great problems of state medicine, so that the profession shall become more capable and honorable within itself, and more useful to the public, in the prevention and cure of disease, and in prolonging and adding comfort to life.

ARTICLE III

COMPONENT SOCIETIES

SECTION 1. Component societies shall consist of those county medical societies which hold charters from this Society.

SEC. 2. The terms, county medical society and component county medical society, shall be deemed to include all county medical societies and academies of medicine now in affiliation with this Society, or which may hereafter be organized and chartered by the House of Delegates of this Society.

ARTICLE IV

COMPOSITION OF THE ASSOCIATION

SECTION 1. This Society shall consist of members who shall be the members of the component county medical societies, and, who shall also be members in good standing of the American Medical Association, and who have been certified to the headquarters of this Society, and all of whose dues and assessments for the current year have been received by the secretary.

SEC. 2. Those members who have been elected to honorary membership by the various component county societies may be enrolled as honorary members of this Society upon approval of the Council. These honorary members shall enjoy all the rights of membership, and their dues to the State Society shall be remitted.

SEC. 3. Members in good standing who shall make outright gifts to the Endowment Fund of this Society, in the amount of $1,000 or more, shall have bestowed upon them the gift of life membership in this Society. Such membership shall carry with it all the perquisites of active membership, without the requirement of annual dues, and shall continue in force during the life of the member, providing that the member continues in good standing in his local county medical society.

*As amended by the 1951 House of Delegates.

ARTICLE V

HOUSE OF DELEGATES

The House of Delegates shall be the legislative body of the Society, and shall consist (1) of delegates elected by the component county medical societies, and one delegate representing each Section of the Society organized under the By-Laws and (2) the officers of the Society enumerated in Section 1 of Article IX of this Constitution, and past presidents of the Society shall be ex officio members, but without the right to vote.

ARTICLE VI

COUNCIL

The Council shall be the Board of Trustees of this Society. The Council shall have full authority and power of the House of Delegates, between annual sessions, unless the House of Delegates shall be called into session as provided in the Constitution and By-Laws. It shall consist of the councilors and the immediate past president. The president, the president-elect, the secretary, the treasurer and the speaker of the House of Delegates shall be ex officio members of the Council, but without the right to vote. Nine of its members shall constitute a quorum.

ARTICLE VII

SECTIONS AND DISTRICT SOCIETIES

The House of Delegates may provide for a division of the scientific work of the Society into appropriate sections, and for the organization of such councilor district societies as will promote the best interests of the profession, such societies to be composed exclusively of members of component county societies.

ARTICLE VIII

SESSIONS AND MEETINGS

SECTION 1. The Society shall hold an annual session during which there shall be at least two general meetings, open to all registered members, delegates and guests.

SEC. 2. The place for holding each annual session shall be fixed by the House of Delegates, or, by failure to act, such authority is delegated to the Council. The time for holding each annual session shall be approved by the Council.

SEC. 3. Special meetings of either the Society or the House of Delegates may be called by a two-thirds vote of the Council or upon petition by twenty delegates.

ARTICLE IX

OFFICERS

SECTION 1. The officers of this Society shall be a president, a president-elect, a secretary, a treasurer, councilors from thirteen districts, and a speaker and vice speaker of the House of Delegates.

Each councilor shall be nominated only by the elected delegates of the county medical society or societies in the district for which he is nominated.

SEC. 2. The officers, except the councilors, shall be elected annually. The terms of the councilors shall be for three years. There shall be elected one councilor for each of the thirteen districts, except that in any councilor district embracing a membership of 250 or more, there shall be elected one addi-

tional councilor for each additional 250 members or major fraction thereof.

As nearly as possible, one third of the members of the Council shall be elected each year. The secretary and the treasurer shall be elected by the Council. All these officers shall serve until their successors are elected and installed.

The president-elect shall automatically succeed the office of president at the conclusion of his one-year term of president-elect.

ARTICLE X

FUNDS AND EXPENSES

SECTION 1. Funds shall be raised by an equal per capita assessment on each component society. The amount of the assessment shall be fixed by the House of Delegates. Funds may also be raised by voluntary contributions, from the Society's publications and in any other manner approved by the House of Delegates. The treasurer and secretary shall submit an annual budget to the Council. All resolutions providing for appropriations shall be referred to the Council and all appropriations approved by the Council shall be included in the annual budget.

SEC. 2. The House of Delegates, by adoption of a by-law, may provide for a special classification of members at per capita reduced dues where such classification may be applied generally throughout the state, and has no special application to individual members or to individual societies.

ARTICLE XI

REFERENDUM

At any general meeting of the Society it may, by a two-thirds vote, order a general referendum upon any question pending before the House of Delegates. The House of Delegates may, by a vote of its members, submit any question to the membership of the Society for its vote. A majority vote of all the members of the Society shall determine the question.

ARTICLE XII

SEAL

The Society shall have a common seal. The power to change or renew the seal shall rest with the House of Delegates.

ARTICLE XIII

AMENDMENTS

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the members of the House present at any annual session, provided that such amendment shall have been presented in open meeting at the previous annual session, and that it shall have been published twice during the year in the bulletin or Journal of this Society, or sent officially to each component society at least two months before the meeting at which final action is to be taken.

BY-LAWS

CHAPTER I

MEMBERSHIP

SECTION 1. The name of a physician on the official roster of this Society, after it has been properly reported by the secretary of his county society, shall be *prima facie* evidence of membership and of his right to register at the annual session.

SEC. 2. No person who is under sentence of suspension or expulsion from any component society of this Society, or whose name has been dropped from its roll of members, shall be entitled to any of the rights or benefits of this Society.

SEC. 3. Each member in attendance at the annual session shall register, when his right to membership has been verified by reference to the records of this Society. No member shall take part in any of the proceedings of the annual session until he has complied with the provisions of this section of the By-Laws.

CHAPTER II

GENERAL MEETINGS

SECTION 1. The general meetings shall be open to all registered members and guests. At such time as may have been arranged, shall be delivered the annual addresses of the president and of the president-elect.

SEC. 2. No address or paper, except those of the president, the president-elect, and the annual orations, or papers presented by out-of-state speakers especially invited, shall occupy more than twenty minutes in its delivery. No member, except by unanimous consent, shall speak more than once in the discussion of any paper nor longer than five minutes at any one time.

SEC. 3. The Council shall establish rules relating to requiring written papers of speakers. All papers read before this Society shall be its property. Each paper, when it has been read, shall be deposited with the secretary. Authors of papers read before this Society shall not cause them to be published elsewhere until after they have been published in its Journal or returned by the Editorial Board. Authors who fail to observe this section shall be ineligible to appear on programs of the State Society for a period of five years.

CHAPTER III

HOUSE OF DELEGATES

SECTION 1. The House of Delegates shall meet annually at the time and place of the annual session.

SEC. 2. Each component county society shall be entitled to send each year one delegate or one corresponding alternate to the House of Delegates for each fifty full-paid members or major fraction thereof in this Society provided, however, that each county society shall be entitled to at least one delegate or one corresponding alternate.

The term "full-paid members," as used in this section, includes regular members of the Society, life members, affiliate members, associate members, and members whose dues are waived or remitted by official action of the Society. Special service members, resident members, partial-pay members, and members who are delinquent in dues payments shall not be included in the term "full-paid members."

For purposes of this section, the number of fully paid members as of a date thirty days in advance of the first session of the House of Delegates at the annual meeting shall determine the number of delegates to which a county medical society may be entitled.

The secretary of each county society shall send a list of such delegates and alternates to the secretary of this Society at least thirty days before the annual session. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions.

SEC. 3. One-fourth of the members of the House of Delegates registered shall constitute a quorum of the House of Delegates. All meetings of the House of Delegates shall be open to members of the Society.

SEC. 4. From among members of the House of Delegates the speaker of the House of Delegates, for the purpose of expediting proceedings, shall appoint Reference Committees to which reports and resolutions shall be referred as follows:

a. On Credentials.
b. On Resolutions.
c. On Reports of Officers.
d. On Reports of Standing Committees.

He shall also appoint such other committees as may be considered by him to be necessary.

SEC. 5. The House of Delegates shall elect delegates to the House of Delegates of the American Medical Association in accordance with the Constitution and By-Laws of that body.

SEC. 6. The House of Delegates shall divide the state into councilor districts, specifying what counties each district shall include, and, when the best interest of the Society and the profession will be promoted thereby, organize in each a district medical society, of which all members of the component county societies shall be members.

SEC. 7. The House of Delegates shall have authority to appoint committees for special purposes from among members of the Society who are not members of the House of Delegates. Such committees shall report to the House of Delegates, and may be present and participate in the debate on their reports.

SEC. 8. It shall approve all memorials and resolutions issued in the name of the Society before they shall become effective.

SEC. 9. Unanimous consent of the House of Delegates shall be required for the introduction of any new resolution or business not filed in proper form with the secretary's office of the Society twenty days before the first session of the House of Delegates. This section shall not apply to new business or resolutions presented by the Council, the constitutional officers, committees of the Society or of the House of Delegates, or officers of the House of Delegates.

CHAPTER IV

ELECTION OF OFFICERS

SECTION 1. The House of Delegates at its first meeting at the annual session shall elect a Committee on Nominations consisting of one delegate from each councilor district. The Committee on Nominations shall report the result of its deliberations to the House of Delegates in the form of a ticket containing the names of one or more members for each of the offices to be filled at that annual session. No two candidates for president-elect shall be from the same district. Each candidate for councilor must be a resident of the district for which he is nominated. Nominations for councilor shall be made from the floor and not from the Committee on Nominations.

SEC. 2. The report of the nominating committee and the election of officers shall be the first order of business of the House of Delegates at the third meeting of the House.

SEC. 3. All elections of officers, where more than one nomination is received, shall be by ballot and a majority of the votes cast shall be necessary to elect except for delegates and alternates to the American Medical Association. In case no nominee receives a majority of the votes on the first ballot, the nominee receiving the lowest number of votes shall be dropped and a new ballot taken. This procedure shall be continued until one of the nominees receives a majority of all the votes cast, when he shall be declared elected. In case no delegates or alternates for the American Medical Association receive on the first ballot a majority of the vote, the nominees shall be declared elected in the order of the highest number of votes received, until the allotted number shall have been chosen. In case of a tie vote for delegate or alternate, the tie shall be determined by lot.

SEC. 4. Nothing in this chapter shall be construed to prevent additional nominations being made from the floor by members of the House of Delegates.

SEC. 5. No person known to have solicited votes for or sought any office within the gift of this Society shall be eligible for any office for two years.

CHAPTER V

DUTIES OF OFFICERS

SECTION 1. The president shall preside at all meetings of the Society; he shall appoint a Committee on Arrangements for the annual session and all committees not otherwise provided for; he shall deliver an annual address at such time as may be arranged, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the state during his term of office, and, as far as practicable, shall visit, by appointment, the various sections of the state and assist the councilors in building up the county societies, and in making their work more practical and useful.

SEC. 2. The president-elect shall act for the president in his absence or disability. If the office of president should become vacant the president-elect shall succeed to the presidency. In case of vacancy in the office of both president and president-elect the Council shall appoint one of its members as acting president until the next meeting of the House of Delegates.

SEC. 3. The treasurer shall give bond in such amount as the Council may provide. He shall demand and receive all funds due the Society, together with bequests and donations. He shall pay money out of the treasury only on a written order of the secretary; he shall subject his accounts to such examination as the House of Delegates may order, and he shall annually render an account of his doings and of the state of the funds in his hands.

SEC. 4. The secretary shall attend the general meetings of the Society and the meetings of the House of Delegates, and shall keep minutes of their respective proceedings. He shall be secretary of the Council. He shall be custodian of all record books and papers belonging to the Society, except such as properly belong to the treasurer, and shall keep account of and promptly turn over to the treasurer all funds of the Society which come into his hands. He shall provide for the registration of the members and delegates at the annual session. He shall, with the cooperation of the secretaries of the component societies, keep a card index register of all the legal practitioners of the state by counties, noting on each his status in relation to his county society, and shall transmit a copy of this list to the American Medical Association, transmitting to its secretary each month a report containing the names of new members and the names of those dropped from the membership roster during the preceding month. He shall conduct the official correspondence, notifying members of meetings, officers of their election and committees of their appointment and duties. He shall employ such assistants as may be ordered by the Council and shall make an annual report to the House of Delegates. He shall supply all component societies with the necessary blanks for making their annual reports, and shall collect from them the

regular per capita assessments and turn the same over to the treasurer. The amount of his salary shall be fixed by the Council.

The Secretary shall maintain certified copies of each component county society's constitution and by-laws, together with any amendments to the same.

SEC. 5. The speaker shall preside at the meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require.

SEC. 6. The vice-speaker shall officiate for the speaker in the latter's absence or at his request. In case of death, resignation, or removal of the speaker, the vice-speaker shall officiate during the unexpired term.

CHAPTER VI

COUNCIL

SECTION 1. The Council shall meet on the day preceding the annual session, and daily *if necessary* during the session and at such other times as necessity *may* require, subject to the call of the chairman or on petition of three councilors. It shall hold an annual meeting during February for purposes of organization and other business. Its chairman shall make an annual report to the House of Delegates.

SEC. 2. Each councilor shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and to keep in touch with the activities of and to aid in the betterment of the component societies of his district. Each councilor shall arrange for an annual conference with the societies within his councilor district, either through individual meetings or district meetings, at which time information shall be brought concerning activities of the State Medical Society and component societies within the district. He shall make an annual report of his work, and of the condition of the profession of each county in his district at the annual session of the Council. The necessary traveling expenses incurred by each councilor in the line of duties herein imposed may be allowed on a proper itemized statement, but this shall not be construed to include his expense in attending the annual session of the Society.

SEC. 3. The Council shall be the executive body of the House of Delegates and between sessions shall exercise the power conferred on the House of Delegates by the Constitution and By-Laws.

The Council shall be the Board of Censors of the Society. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to the component societies, or to this Society. All questions of an ethical nature brought before the House of Delegates or the general meeting shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members or component societies, on which an appeal is taken. Its decision in all cases, including questions regarding membership in this Society, shall be final.

SEC. 4. Charters shall be issued to county societies only on approval of the Council, and shall be signed by the president and secretary of this Society. Upon the recommendation of the Council, the House of Delegates may revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and By-Laws.

SEC. 5. In sparsely settled sections the Council shall have authority to organize the physicians of two or more counties into societies, to be suitably designed so as to distinguish them from district societies, and these societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

SEC. 6. The Council shall provide for and superintend the issuance of all publications of the Society including proceedings, transactions and memoirs, and shall have authority to appoint an editor of the Journal and such assistants as it deems necessary. It shall prescribe the methods of accounting and through a committee of three of its members to be known as a Committee on Auditing and Finance, shall audit all accounts of this Society, and with the treasurer, supervise the investment of funds. The Council shall adopt an annual budget providing for the necessary expenses of the Society, which shall be prepared and presented for its consideration by the treasurer and secretary at the first meeting of the Council in January of each year. Its chairman shall submit an annual report to the House of Delegates, which shall specify the character and cost of the publications of the Society, the amount and character of all of its property, and shall provide full information concerning the management of all affairs of the Society which the Council is charged to administer.

SEC. 7. The Council shall, by appointment, fill any vacancy in office not otherwise provided for which may occur during the interval between annual meetings of the House of Delegates; the appointee shall serve until his successor has been elected and has qualified.

SEC. 8. The Council may elect as secretary one who need not be a physician nor a member of the Society.

SEC. 9. The salaries of all employees of the Society shall be fixed by the Council.

SEC. 10. The Council shall provide such headquarters for the Society as may be required to conduct its business properly.

CHAPTER VII

COMMITTEES

SECTION 1. The standing committees of this Society shall be as follows:

A Council on Scientific Work.
A Council on Medical Service.
A Committee on Public Policy.
A Committee on Grievances.
A Committee on Medical Education and Hospitals.
A Committee on Maternal and Child Welfare.
A Committee on Care of Crippled Children.
A Committee on Goiter.
A Committee on Mental Hygiene, Institutional Care, Public Welfare and State Departments.
A Committee Advisory to the Woman's Auxiliary.
A Committee on Tuberculosis and Chest Diseases.
A Committee on Hospital Relations.
A Committee on Cancer.
A Committee on Visual Defects.
A Committee on Hearing Defects.

Unless otherwise provided in these By-Laws, each of these committees shall consist of five members, each of whom shall serve for a term of five years. One member of each of these committees shall be appointed annually by the incoming president, by and with the consent of the House of Delegates, provided that where the House creates a new standing committee the original appointments shall be for terms of one, two, three, four, and five years, and thereafter for terms of five years each.

SEC. 2. The Council on Scientific Work shall consist of five members, and each member shall serve for a period of five years. The Council on Scientific Work shall study the character and scope of the scientific proceedings of the Society and shall prepare the scientific program for the annual meeting. It shall likewise study the field of postgraduate education, making available, so far as lies within its power, program material for such postgraduate education both through programs of component societies and in such other ways as it may find feasible. It shall also be in charge of the affairs of the Journal. Important questions of editorial policy shall be submitted to the Council of the Society and an annual report shall be made to the House of Delegates.

SEC. 3. The Council on Medical Service shall consist of nine members appointed by the president of the Society. Appointments shall be so made that the terms of one-third of the members expire each year. The Council on Medical Service shall act to correlate activities of the Society in medical economic fields, and to inform the profession and the public of proposed changes affecting medical care in the state and the nation. It shall likewise study and suggest means for the improvement of the distribution of medical service to the public, and shall periodically inform county medical societies regarding its activities.

The Council shall direct the program of the Society in the field of public health education, and in such manner as is found suitable, shall seek to further the health of those employed in Wisconsin industry, as well as to promote the health and safety of those engaged in rural Wisconsin.

SEC. 4. The Committee on Public Policy shall consist of five members, and the president, the president-elect and secretary. The committee shall present to those public officers charged with the duty of enacting or enforcing measures in the interest of public health, all available information that may in any way assist such officers honorably to discharge their responsibilities.

SEC. 5. The Committee on Grievances shall investigate all reported claims against members for compensation for injuries said to have resulted from malpractice. It shall determine as nearly as may be practicable the circumstances leading up to the making of the claim itself and the grounds on which the claim is based. The committee shall recommend to the Society from time to time such measures as it deems practicable for the limitation or removal of the causes of such claims. It may, at the request of any member against whom a claim has been made, place at his disposal such evidence as becomes available to the committee. If the committee believes a claim unjust, it shall, at the request of the member against whom the claim has been made, cooperate, so far as it can lawfully do so, with him and his counsel in defense against it. If the committee believes that the claim that it has investigated is a just claim, the committee may, at the request of the member against whom the claim was made, cooperate with him and his counsel, so far as it lawfully can do so, in effecting an equitable settlement. The committee shall submit a report of its proceedings at each annual meeting of the Society, covering the preceding year, in which report shall be included all recommendations made by the committee during the year looking toward the removal of the causes of claims based on alleged malpractice. The committee shall possess similar responsibilities where request is made to investigate complaints bearing upon a member's alleged violation of any provision of the Medical Practice Act.

The committee shall consist of six members and the terms of one-third of its members shall expire each year, with each member appointed for a term of three years.

SEC. 6. The Committee on Medical Education and Hospitals shall serve in this state for the Council on Medical Education and Hospitals of the American Medical Association, and shall have referred to it all questions pertaining to hospitals and medical education.

The deans of the two Medical Schools in Wisconsin shall be members of this Committee, in addition to those appointed annually.

SEC. 7. The Committee on Maternal and Child Welfare shall consist of six members and its principal duties shall be to advise cooperating agencies in the effort to reduce maternal mortality and to preserve child health.

SEC. 8. The Committee on Care of Crippled Children shall consist of six members, and its principal duty shall be to act in an advisory capacity to state departments concerned with the subject matter.

SEC. 9. The Committee on Goiter shall consist of five members, and its principal duty shall be to forward those measures looking toward the prevention of goiter, and where existent, its early diagnosis and treatment.

SEC. 10. The Committee on Mental Hygiene, Institutional Care, Public Welfare and State Departments shall consist of five members. Its principal duties shall be advisory to both the Society and cooperating agencies as to those means best designed to protect mental health and alleviate mental illness.

SEC. 11. The Committee Advisory to the Woman's Auxiliary shall consist of the chairman of the Council, the immediate past president, the president, the president-elect, and the secretary. Its principal duties shall be to advise state officers of the Auxiliary, particularly in the field of approval of new projects.

SEC. 12. The Committee on Tuberculosis and Chest Diseases shall consist of five members, and its principal duties shall be advisory to the Society and cooperating agencies as to those means best designed to aid in the prevention and alleviation of tuberculosis and diseases of the chest.

SEC. 13. The Committee on Hospital Relations shall consist of six members, and each member shall serve for a period of three years. Of the original appointments, two members shall be appointed for a term of one year, two members for a term of two years, and two members for a term of three years, and thereafter for terms of three years each. The principal duty of this committee shall be to consider, investigate and study the interrelationship of the medical profession to the hospital institutions, and to act in an advisory capacity to the Society.

The Committee on Hospital Relations of the State Medical Society of Wisconsin is specifically charged with the responsibility of receiving and considering all complaints and/or queries from any physician, hospital, medical organization, or other interested person or group, relating to professional and/or economic problems occurring in the practice of medicine in hospitals wherein a dispute has arisen between a physician and a hospital. If the matter under consideration cannot be arbitrated by the good offices of the Committee on Hospital Relations, its findings to that effect shall be transmitted to the Council of the State Medical Society of Wisconsin with its findings and recommendations in order that

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the Council may then make suitable recommendations to the Judicial Council of the American Medical Association.

SEC. 14. The Committee on Cancer shall consist of a member appointed from each of the councilor districts of the State Society, and its principal duties shall be advisory to the Society and cooperating agencies as to those means best designed to aid in the prevention and alleviation of cancer. As nearly as possible, the terms of one-third of the members of the committee shall expire each year, with each committee member being appointed for a term of three years.

SEC. 15. The Committee on Visual Defects shall consist of five members, and its principal duties shall lie in the field of prevention, and where existent, early discovery and treatment. It shall act in an advisory capacity to state departments concerned with these problems.

SEC. 16. The Committee on Hearing Defects shall consist of five members, and its principal duties shall lie in the field of prevention and, where existent, early discovery and treatment. It shall act in an advisory capacity to State departments concerned with these problems. Appointments to this Committee in 1948 shall be for three, four and five year terms, and appointments thereafter shall be for a term of five years.

SEC. 17. The Wisconsin Medical Journal shall be the official Journal of the Society.

CHAPTER VIII

DUES AND ASSESSMENTS

SECTION 1. The annual dues and assessments shall be determined by the House of Delegates, and shall be levied per capita on the members of the Society. They shall be payable on or before January 1 of the year for which they are levied. The secretary of each component society shall cause to be collected and shall forward to the offices of the Society the dues and assessments for its members, together with such data as shall be required for a record of its officers and membership. Any member whose name has not been reported for enrollment and whose dues for the current year have not been remitted to the secretary of this Society on or before March 31 shall stand suspended until his name is properly reported and his dues for the current year properly remitted.

An active member in good standing in his county society who has for thirty-five continuous years been a member of this State Society shall receive a special certificate and plaque indicating the completion of such period of membership.

SEC. 2. *Life Membership.* An active member who shall have been a member of his county and state medical societies in Wisconsin continuously for fifty consecutive years shall be offered the status of a life member, and if he accepts shall enjoy full membership privileges, but shall be exempt from the payment of dues or assessments. He shall receive a certificate of life membership.

SEC. 3. *Affiliate Membership.* An active member in good standing in his county society may, upon the recommendation of the secretary and president of the county medical society and with approval of the State Medical Society, be granted affiliate membership with full voting and other privileges. Such membership shall be on an annual basis only, and shall be granted where such member suffers a physical or other disability preventing the practice of medicine with resulting serious financial reverses that would make payment of dues a matter of personal hardship.

SEC. 4. *Associate Membership.* A member in good standing in his county society, who has retired completely from the practice of medicine, may apply for associate membership. With approval of his county society and of the Council, such membership shall be granted on payment of $10 annual dues.

SEC. 5. The record of payment of dues and assessments on file in the offices of the Society shall be final as to the fact of payment by a member and as to his right to participate in the business and proceedings of the Society and of the House of Delegates.

SEC. 6. Any county society which fails to make the reports required, at least thirty days before the annual session of the State Society, shall be held suspended, and none of its members or delegates shall be permitted to participate in any of the proceedings of the Society or of the House of Delegates.

CHAPTER IX

The ethical principles governing the members of the American Medical Association shall govern members of this Society. No member shall profess adherence or give support to any exclusive dogma, sect or school.

CHAPTER X

The deliberations of this Society, except as may be provided otherwise in the Constitution and By-Laws, shall be conducted in accordance with parliamentary usage as defined in Roberts' Rules of Order.

CHAPTER XI

SECTION 1. All county societies now in affiliation with the State Society or those that may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and By-Laws shall, upon application to the Council, receive charters from this Society, provided that their constitutions and by-laws shall have been submitted to the Council and received its approval.

SEC. 2. Only one component medical society shall be chartered in each county.

SEC. 3. Each county society shall judge of the qualifications of its members, subject to review and final decision by the Council of the State Society. Every reputable and legally qualified physician who is a citizen of the United States and who is a bona fide resident of the same county shall be eligible to apply for membership so long as he does not practice nor profess to practice sectarian medicine, or engage in practice in a manner in conflict with the Principles of Ethics of the American Medical Association, or so conduct himself as to defeat the purposes for which the Society is organized and is operating. By proper provision of constitution and by-laws, either or both as may be necessary, the county society may require of an applicant for membership that he shall have resided within the jurisdiction of the society to which he is applying, for a period of one year as a condition precedent to election to membership; or the county society may provide that an applicant for membership first may be elected to membership for a term of only one year, with the provision that such membership shall then terminate, and the member resubmit to election, without limitation as to term, by vote of the society.

A member of a component society whose license has been revoked shall be dropped from membership automatically as of the date of revocation. The Council of the State Society shall have final

authority to expel a member should a component county society fail to do so after being so requested by the Council.

A physician living near a county line may hold his membership in that county most convenient for him to attend, on permission of the component society in whose jurisdiction he resides.

A member who removes his principal practice from within the territorial limits of a county medical society in which he shall hold membership, shall not be eligible to continue his membership in such society after the expiration of the calendar year in which such removal shall have occurred. Such member shall, however, be eligible to apply for membership anew or by transfer to the society in whose jurisdiction his principal practice shall have been removed.

By proper provision of Constitution and By-Laws, either or both as may be necessary, a county society may admit to membership those in training as hospital residents or as research fellows who are licensed to practice medicine and surgery in the state of Wisconsin, upon the payment of dues not to exceed $5 annually, of which at least $3 shall be remitted to the State Society, provided that any applicant so elected shall not be permitted such membership beyond a period of three years from the date of such election, and shall not be included as a "fully paid" member as that term is used in Section 2 of Chapter III.

SEC. 4. Any physician who may feel aggrieved by the action of the society of his county in suspending or expelling him shall have the right to appeal to the Council, whose decision shall be final. A county society shall at all times be permitted to appeal or refer questions involving membership to the Council of the State Society for final determination. The period of time within which appeal to the Council may be taken shall be limited to six months following the date of decision by the constituted authority of a component county medical society.

SEC. 5. In hearing appeals the Council may admit oral or written evidence as in its judgment will most fairly present the facts, but in the case of every appeal both as a board and as individuals, the councilors shall, preceding all such hearings, make efforts at conciliation and compromise.

SEC. 6. When a member in good standing in a component county society moves to another county in this state, he shall be given a written certificate of these facts by the secretary of his society, without cost, for transmission to the secretary of the society in the county to which he moves. Pending his acceptance or rejection by the society in the county to which he removes, such member shall be considered to be in good standing in the county society from which he was certified and in the State Society to the end of the period (respectively) for which his dues have been paid.

SEC. 7. Each county society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material condition of every physician in the county. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it includes every eligible physician in the county.

SEC. 8. At some meeting in advance of the annual session of this Society, each component county society shall elect one or more delegates and an equal number of individual alternates therefor to represent it in the House of Delegates of this Society, in accordance with Chapter III, Section 2, of these By-Laws. The secretary of each county society shall send a list of such delegates and alternates to the secretary of this Society at least thirty days before the annual session. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions.

SEC. 9. The secretary of each county society shall keep a roster of its members, and, if practicable, a list of nonaffiliated physicians, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary by Council. He shall send a copy of the program of each county meeting to his district councilor and to the secretary.

SEC. 10. Each county society shall appoint or elect one or more of its members as a member of an auxiliary Committee on Public Policy, and the county society secretary shall send his name and address at once to the secretary of this Society. The Committee on Public Policy of this Society shall formulate the duties of this auxiliary committee and supply each member with a copy. The auxiliary committeemen shall be accountable to their county societies and to the Council for prompt response to and continued cooperation with the Committee on Public Policy of this Society.

CHAPTER XII

SCIENTIFIC SECTIONS

SECTION 1. The House of Delegates shall, from time to time, establish such scientific sections within the Society as it may determine and shall have the power to combine, enlarge, or discontinue any or all of such sections so established.

SEC. 2. Such sections so established shall be based upon those divisions of medicine in which the various members possess a special interest, but qualifications for membership in any section may be prescribed by the members of such section, subject only to approval of the Council, except that scientific meetings of the section shall be open to all members in good standing of the State Medical Society.

SEC. 3. The officers of any such section shall be those prescribed by the members thereof. The terms of such officers shall be for the term of one year, but any officer may be reelected.

SEC. 4. The officers of any such section shall constitute the executive committee thereof, and a majority of the executive committee must vote with the majority of the members in order for any action of the section to be effective. The executive committee shall have the power to appoint such committees within a section as it deems necessary from time to time.

SEC. 5. No section shall have the power to bind the Society by any resolution or other action, or to publicize the same, unless the same shall first be approved by the House of Delegates, or by a majority of the members of the Council when the House of Delegates is not in session. No resolution adopted by any section shall be effective until likewise so approved.

SEC. 6. Each section so established shall have the privilege of electing a delegate and alternate to the House of Delegates.

CHAPTER XIII

SECTION 1. These By-Laws may be amended at any annual session by a majority vote of the delegates present at that session, if the proposed amendment has been properly submitted to the House of Delegates and has laid over for one day.

SEC. 2. Upon the adoption of this Constitution and these By-Laws, all previous Constitutions and By-Laws are thereby repealed.

Principles of Medical Ethics of the American Medical Association

"These principles are not laws to govern but are principles to guide to correct conduct." (James Percival's Principles of Ethics 1803).

CHAPTER 1

GENERAL PRINCIPLES

CHARACTER OF THE PHYSICIAN

SECTION 1.—The prime object of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. Whoever chooses this profession assumes the obligation to conduct himself in accord with its ideals. A physician should be "an upright man, instructed in the art of healing." He must keep himself pure in character and be diligent and conscientious in caring for the sick. As was said by Hippocrates, "He should also be modest, sober, patient, prompt to do his whole duty without anxiety; pious without going so far as superstition, conducting himself with propriety in his profession and in all the actions of his life."

THE PHYSICIAN'S RESPONSIBILITY

SEC. 2.—"The profession of medicine, having for its end the common good of mankind, knows nothing of national enmities, of political strife, of sectarian dissensions. Disease and pain the sole conditions of its ministry, it is disquieted by no misgivings concerning the justice and honesty of its client's cause; but dispenses its peculiar benefits, without stint or scruple, to men of every country, and party and rank, and religion, and to men of no religion at all."*

GROUPS AND CLINICS

SEC. 3.—The ethical principles actuating and governing a group or clinic are exactly the same as those applicable to the individual. As a group or clinic is composed of individual physicians, each of whom, whether employer, employee or partner, is subject to the principles of ethics herein elaborated, the uniting into a business or professional organization does not relieve them either individually or as a group from the obligation they assume when entering the profession.

ADVERTISING

SEC. 4.—Solicitation of patients, directly or indirectly, by a physician, by groups of physicians or by institutions or organizations is unethical. This principle protects the public from the advertiser and salesman of medical care by establishing an easily discernible and generally recognized distinction between him and the ethical physician. Among unethical practices are included the not always obvious devices of furnishing or inspiring newspaper or magazine comments concerning cases in which the physician or group or institution has been, or is, concerned. Self laudations defy the traditions and lower the moral standard of the medical profession; they are an infraction of good taste and are disapproved.

EDUCATION INFORMATION NOT ADVERTISING

SEC. 5.—Many people, literate and well educated, do not possess a special knowledge of medicine. Medical books and journals are not easily accessible or readily understandable.

The medical profession considers it ethical for a physician to meet the request of a component or constituent medical society to write, act or speak for general readers or audiences. The adaptability of medical material for presentation to the public may be perceived first by publishers, motion picture producers or radio officials. These may offer to the physician opportunity to release to the public some article, exhibit or drawing. Refusal to release the material may be considered a refusal to perform a public service, yet compliance may bring the charge of self seeking or solicitation. In such circumstances the physician should be guided by the decision of official agencies established through component and constituent medical organizations.

A physician who desires to know whether, ethically, he may engage in a project aimed at health education of the public should request the approval of the designated officer or committee of his county medical society.

The most worthy and effective advertisement possible, even for a young physician, especially among his brother physicians, is the establishment of a well merited reputation for professional ability and fidelity. This cannot be forced, but must be the outcome of character and conduct. The publication or circulation of simple professional cards is approved in some localities but is disapproved in others. Disregard of local customs and offenses against recognized ideals are unethical.

The promise of radical cures or boasting of cures or of extraordinary skill or success is unethical.

An institution may use means, approved by the medical profession in its own locality, to inform the public of its address and the special class, if any, of patients accommodated.

PATENTS, COMMISSIONS, REBATES AND SECRET REMEDIES

SEC. 6.—An ethical physician will not receive remuneration from patents on or the sale of surgical instruments, appliances and medicines, nor

* Sir Thomas Watson.

profit from a copyright on methods or procedures. The receipt of remuneration from patents or copyrights tempts the owners thereof to retard or inhibit research or to restrict the benefits derivable therefrom to patients, the public or the medical profession. The acceptance of rebates on prescriptions or appliances, or of commissions from attendants who aid in the care of patients is unethical. An ethical physician does not engage in barter or trade in the appliances, devices or remedies prescribed for patients, but limits the sources of his professional income to professional services rendered the patient. He should receive his remuneration for professional services rendered only in the amount of his fee specifically announced to his patient at the time the service is rendered or in the form of a subsequent statement, and he should not accept additional compensation secretly or openly, directly or indirectly, from any other source.

The prescription or dispensing by a physician of secret medicines or other secret remedial agents, of which he does not know the composition, or the manufacture or promotion of their use is unethical.

EVASION OF LEGAL RESTRICTIONS

SEC. 7.—An ethical physician will observe the laws regulating the practice of medicine and will not assist others to evade such laws.

CHAPTER II

DUTIES OF PHYSICIANS TO THEIR PATIENTS

STANDARDS, USEFULNESS, NONSECTARIANISM

SEC. 1.—In order that a physician may best serve his patients, he is expected to exalt the standards of his profession and to extend its sphere of usefulness. To the same end, he should not base his practice on an exclusive dogma or a sectarian system, for "sects are implacable despots; to accept their thralldom is to take away all liberty from one's action and thought."* A sectarian or cultist as applied to medicine is one who alleges to follow or in his practice follows a dogma, tenet or principle based on the authority of its promulgator to the exclusion of demonstration and scientific experience. All voluntarily associated activities with cultists are unethical. A consultation with a cultist is a futile gesture if the cultist is assumed to have the same high grade of knowledge, training and experience as is possessed by the doctor of medicine. Such consultation lowers the honor and dignity of the profession in the same degree in which it elevates the honor and dignity of those who are irregular in training and practice.

PATIENCE, DELICACY AND SECRECY

SEC. 2.—Patience and delicacy should characterize the physician. Confidences concerning individual or domestic life entrusted by patients to a physician and defects in the disposition or character of patients observed during medical attendance should never be revealed unless their revelation is required by the laws of the state. Sometimes, however, a physician must determine whether his duty to society requires him to employ knowledge, obtained through confidences entrusted to him as a physician, to protect a healthy person against a communicable disease to which he is about to be exposed. In such instance, the physician should act as he would desire another to act toward one of his own family in like circumstances. Before he determines his course, the physician should know the civil law of his commonwealth concerning privileged communications.

PROGNOSIS

SEC. 3.—The physician should neither exaggerate nor minimize the gravity of a patient's condition. He should assure himself that the patient, his relatives or his responsible friends have such knowledge of the patient's condition as will serve the best interests of the patient and the family.

THE PATIENT MUST NOT BE NEGLECTED

SEC. 4.—A physician is free to choose whom he will serve. He should, however, respond to any request for his assistance in an emergency or whenever temperate public opinion expects the service. Once having undertaken a case, the physician should not neglect the patient, nor should he withdraw from the case without giving notice to the patient, his relatives or his responsible friends sufficiently long in advance of his withdrawal to allow them to secure another medical attendant.

CHAPTER III

DUTIES OF PHYSICIANS TO EACH OTHER AND TO THE PROFESSION AT LARGE

ARTICLE I.—DUTIES TO THE PROFESSION

UPHOLDING THE HONOR OF THE PROFESSION

SEC. 1.—A physician is expected to uphold the dignity and honor of his vocation.

MEMBERSHIP IN MEDICAL SOCIETIES

SEC. 2.—For the advancement of his profession, a physician should affiliate with medical societies and contribute of his time, energy and means so that these societies may represent the ideals of the profession.

SAFEGUARDING THE PROFESSION

SEC. 3.—Every physician should aid in safeguarding the profession against admission to it of those who are deficient in moral character or education.

SEC. 4.—A physician should expose, without fear or favor, incompetent or corrupt, dishonest or unethical conduct on the part of members of the profession. Questions of such conduct should be consid-

* Nicon, father of Galen.

ered, first, before proper medical tribunals in executive sessions or by special or duly appointed committees on ethical relations, provided such a course is possible and provided, also, that the law is not hampered thereby. If doubt should arise as to the legality of the physician's conduct, the situation under investigation may be placed before officers of the law, and the physician-investigators may take the necessary steps to enlist the interest of the proper authority.

Article II.—Professional Services of Physicians to Each Other

DEPENDENCE OF PHYSICIANS ON EACH OTHER

Sec. 1.—As a general rule, a physician should not attempt to treat members of his family or himself. Consequently, a physician should cheerfully and without recompense give his professional services to physicians or their dependents if they are in his vicinity.

COMPENSATION FOR EXPENSES

Sec. 2.—When a physician from a distance is called to advise another physician about his own illness or about that of one of his family dependents, and the physician to whom the service is rendered is in easy financial circumstances, a compensation that will at least meet the traveling expenses of the visiting physician should be proffered him. When such a service requires an absence from the accustomed field of professional work of the visitor that might reasonably be expected to entail a pecuniary loss, such loss may, in part at least, be provided for in the compensation offered.

ONE PHYSICIAN IN CHARGE

Sec. 3.—When a physician or a member of his dependent family is seriously ill, he or his family should select one physician to take charge of the case. The family may ask the physician in charge to call in other physicians to act as consultants.

Article III.—Duties of Physicians in Consultations

CONSULTATIONS SHOULD BE ENCOURAGED

Sec. 1.—In a case of serious illness, especially in doubtful or difficult conditions, the physician should request consultations.

CONSULTATION FOR PATIENT'S BENEFIT

Sec. 2.—In every consultation, the benefit to the patient is of first importance. All physicians interested in the case should be candid with the patient, a member of his family or a responsible friend.

PUNCTUALITY

Sec. 3.—All physicians concerned in consultations should be punctual. When, however, one or more of the consultants are unavoidably delayed, the one who arrives first should wait for the others for a reasonable time, after which the consultation should be considered postponed. When the consultant has come from a distance, or when for any other reason it will be difficult to meet the physician in charge at another time, or if the case is urgent, or it be the desire of the patient, his family or his responsible friends, the consultant may examine the patient and mail his written opinion, or see that it is delivered under seal to the physician in charge. Under these conditions, the consultant's conduct must be especially tactful; he must remember that he is framing an opinion without the aid of the physician who has observed the course of the disease.

PATIENT REFERRED TO CONSULTANT

Sec. 4.—When a patient is sent to a consultant and the physician in charge of the case cannot accompany the patient, the physician in charge should provide the consultant with a history of the case, together with the physician's opinion and outline of the treatment, or so much of this as may be of service to the consultant. As soon as possible after the consultant has seen the patient he should address the physician in charge and advise him of the results of the consultant's investigation. The opinions of both the physician in charge and the consultant are confidential and must be so regarded by each.

DISCUSSIONS IN CONSULTATIONS

Sec. 5.—After the physicians called in consultation have completed their investigations, they and the physician in charge should meet by themselves to discuss the course to be followed. Statements should not be made nor should discussion take place in the presence of the patient, his family or his friends, unless all physicians concerned are present or unless all of them have consented to another arrangement.

RESPONSIBILITY OF ATTENDING PHYSICIAN

Sec. 6.—The physician in charge of the case is responsible for treatment of the patient. Consequently, he may prescribe for the patient at any time and is privileged to vary the treatment outlined and agreed on at a consultation whenever, in his opinion, such a change is warranted. However, after such a change, it is best to call another consultation; then the physician in charge should state his reasons for departing from the course decided at the previous conference. When an emergency occurs during the absence of the physician in charge, a consultant may assume authority until the arrival of the physician in charge, but his authority should not extend further without the consent of the physician in charge.

CONFLICT OF OPINION

Sec. 7.—Should the physician in charge and a consultant be unable to agree in their view of a case, another consultant should be called or the

differing consultant should withdraw. However, since the patient employed the consultant to obtain his opinion, he should be permitted to state it to the patient, his relative or his responsible friend, in the presence of the physician in charge.

CONSULTANT AND ATTENDANT

SEC. 8.—When a physician has acted as consultant in an illness, he should not become the physician in charge in the course of that illness, except with the consent of the physician who was in charge at the time of the consultation.

ARTICLE IV.—DUTIES OF PHYSICIANS IN CASES OF INTERFERENCE

MISUNDERSTANDINGS TO BE AVOIDED

SEC. 1.—A physician, in his relationship with a patient who is under the care of another physician, should not give hints relative to the nature and treatment of the patient's disorder; nor should a physician do anything to diminish the trust reposed by the patient in his own physician. In embarrassing situations, or whenever there seems to be a possibility of misunderstanding with a colleague, a physician should seek a personal interview with his fellow.

SOCIAL CALLS ON PATIENTS OF ANOTHER PHYSICIAN

SEC. 2.—When a physician makes social calls on another physician's patient he should avoid conversation about the patient's illness.

SERVICES TO PATIENT OF ANOTHER PHYSICIAN

SEC. 3.—A physician should not take charge of, or prescribe for another physician's patient during any given illness (except in an emergency) until the other physician has relinquished the case or has been formally dismissed.

CRITICISM TO BE AVOIDED

SEC. 4.—When a physician does succeed another physician in charge of a case, he should not disparage, by comment or insinuation, the one who preceded him. Such comment or insinuation tends to lower the confidence of the patient in the medical profession and so reacts against the patient, the profession and the critic.

EMERGENCY CASES

SEC. 5.—When a physician is called in an emergency because the personal or family physician is not at hand, he should provide only for the patient's immediate need and should withdraw from the case on the arrival of the personal or family physician. However, he should first report to the personal or family physician the condition found and the treatment administered.

PRECEDENCE WHEN SEVERAL PHYSICIANS ARE SUMMONED

SEC. 6.—When several physicians have been summoned in a case of sudden illness or of accident, the first to arrive should be considered the physician in charge. However, as soon as is practicable, or on the arrival of the acknowledged personal or family physician, the first physician should withdraw. Should the patient, his family or his responsible friend wish some one other than he who has been in charge of the case, the patient or his representative should advise the personal or family physician of his desire. When, because of sudden illness or accident, a patient is taken to a hospital without the knowledge of the physician who is known to be the personal or family physician, the patient should be returned to the care of the personal or family physician as soon as is feasible.

A COLLEAGUE'S PATIENT

SEC. 7.—When a physician is requested by a colleague to care for a patient during the colleague's temporary absence, or when, because of an emergency, a physician is asked to see a patient of a colleague, the physician should treat the patient in the same manner and with the same delicacy that he would wish used in similar circumstances if the patient were his responsibility. The patient should be returned to the care of the attending physician as soon as possible.

SUBSTITUTION IN OBSTETRIC WORK

SEC. 8.—When a physician attends a woman who is in labor because the one who was engaged to attend her is absent, the physician summoned in the emergency should relinquish the patient to the first engaged, on his arrival. The one in attendance is entitled to compensation for the professional services he may have rendered.

ARTICLE V.—DISPUTES BETWEEN PHYSICIANS

ARBITRATION

SEC. 1.—Whenever there arises between physicians a grave difference of opinion, or of interest, which cannot be promptly adjusted, the dispute should be referred for arbitration, preferably to an official body of a component society.

ARTICLE VI.—COMPENSATION

LIMITS OF GRATUITOUS SERVICE

SEC. 1.—Poverty of a patient, and the obligation of physicians to attend one another and the dependent members of the families of one another, should command the gratuitous services of a physician. Institutions and organizations for mutual benefit, or for accident, sickness and life insurance, or for analogous purposes, should meet such costs as are covered by the contract under which the service is rendered.

CONDITIONS OF MEDICAL PRACTICE

SEC. 2.—A physician should not dispose of his services under conditions that make it impossible to render adequate service to his patients, except under circumstances in which the patients concerned might be deprived of immediately necessary care.

CONTRACT PRACTICE

SEC. 3.—Contract practice as applied to medicine means the practice of medicine under an agreement between a physician or a group of physicians, as principals or agents, and a corporation, organization, political subdivision or individual, whereby partial or full medical services are provided for a group or class of individuals on the basis of a fee schedule, or for a salary or for a fixed rate per capita.

Contract practice *per se* is not unethical. Contract practice is unethical if it permits of features or conditions that are declared unethical in these Principles of Medical Ethics or if the contract or any of its provisions causes deterioration of the quality of the medical services rendered.

FREE CHOICE OF PHYSICIAN

SEC. 4.—Free choice of physician is defined as that degree of freedom in choosing a physician which can be exercised under usual conditions of employment between patients and physicians. The interjection of a third party who has a valid interest, or who intervenes between the physician and the patient does not *per se* cause a contract to be unethical. A third party has a valid interest when, by law or violation, the third party assumes legal responsibility and provides for the cost of medical care and indemnity for occupational disability.

COMMISSIONS

SEC. 5.—When a patient is referred by one physician to another for consultation or for treatment, whether the physician in charge accompanies the patient or not, the giving or receiving of a commission by whatever term it may be called or under any guise or pretext whatsoever is unethical.

PURVEYAL OF MEDICAL SERVICE

SEC. 6.—A physician should not dispose of his professional attainments or services to any hospital, lay body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit exploitation of the services of the physician for the financial profit of the agency concerned. Such a procedure is beneath the dignity of professional practice and is harmful alike to the profession of medicine and the welfare of the people.

CHAPTER IV

THE DUTIES OF PHYSICIANS TO THE PUBLIC

PHYSICIANS AS CITIZENS

SEC. 1.—Physicians, as good citizens, possessed of special training, should advise concerning the health of the community wherein they dwell. They should bear their part in enforcing the laws of the community and in sustaining the institutions that advance the interests of humanity. They should cooperate especially with the proper authorities in the administration of sanitary laws and regulations.

PUBLIC HEALTH

SEC. 2.—Physicians, especially those engaged in public health work, should enlighten the public concerning quarantine regulations and measures for the prevention of epidemic and communicable diseases. At all times the physician should notify the constituted public health authorities of every case of communicable disease under his care, in accordance with the laws, rules and regulations of the health authorities. When an epidemic prevails, a physician must continue his labors without regard to the risk to his own health.

PHARMACISTS

SEC. 3.—Physicians should recognize and promote the practice of pharmacy as a profession and should recognize the cooperation of the pharmacist in education of the public concerning the practice of ethical and scientific medicine.

CONCLUSION

These principles of medical ethics have been and are set down primarily for the good of the public and should be observed in such a manner as shall merit and receive the endorsement of the community. The life of the physician, if he is capable, honest, decent, courteous, vigilant and a follower of the Golden Rule, will be in itself the best exemplification of ethical principles.

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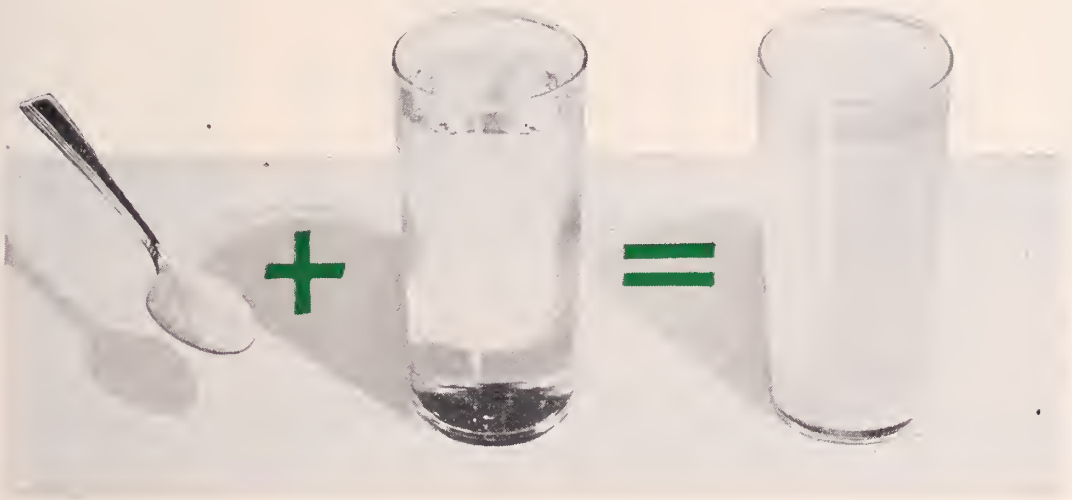

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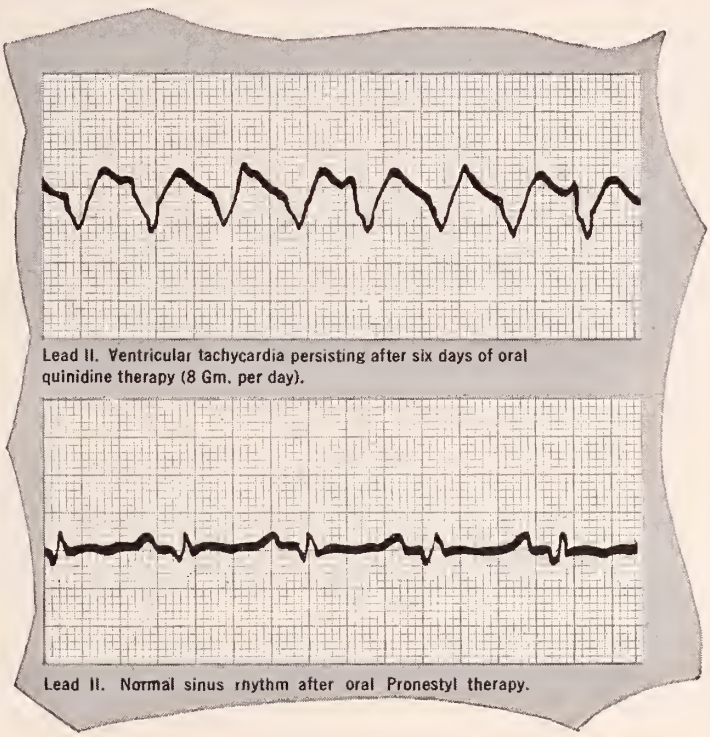

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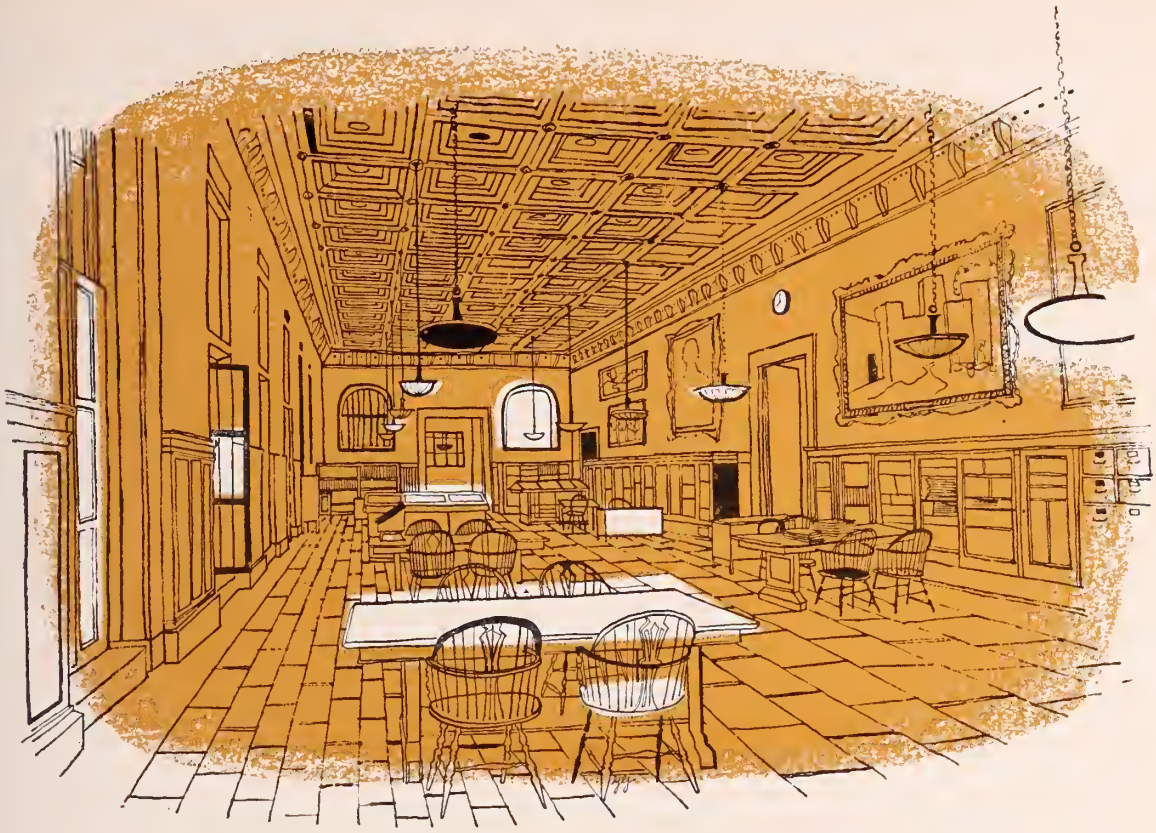

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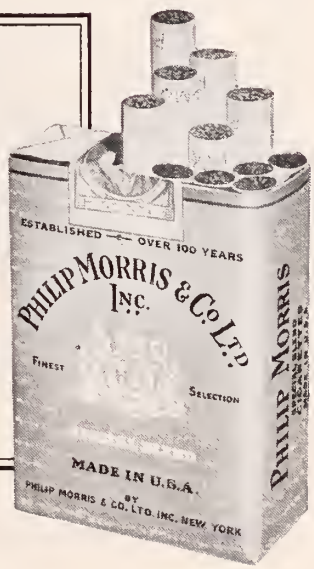

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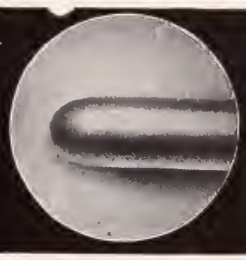

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Address as follows: Medical Library Service, Service Memorial Institute Building, North Charter Street, Madison, Wisconsin.

The Physician Examines the Bible. By C. Raimer Smith, B.S., M.D., D.N.B. New York, Philosophical Library, 1950. Price $4.25.

The author's avowed purpose in the publishing of this work as stated in his introduction is the examination of the Bible from the medical standpoint. It is my opinion that from this beginning the author has entirely failed to hit his mark for several reasons. Chief of these is because he has scattered his shot too widely. Not contented with the field of medicine per se, he spends a good portion of his book taking relatively uninformed flyers into such fields as astronomy, geology, epic poetry, along with several others. The book very quickly degenerates into a mere listing of signs, symptoms, classes, diseases, and above all biblical verses. Very frequently the author does not take the time to quote his biblical references, but merely gives the reader the Book, chapter and verse, so that it would be necessary to accompany the reading of this work by periodically paging through a copy of the Bible as if it were a dictionary or thesaurus.

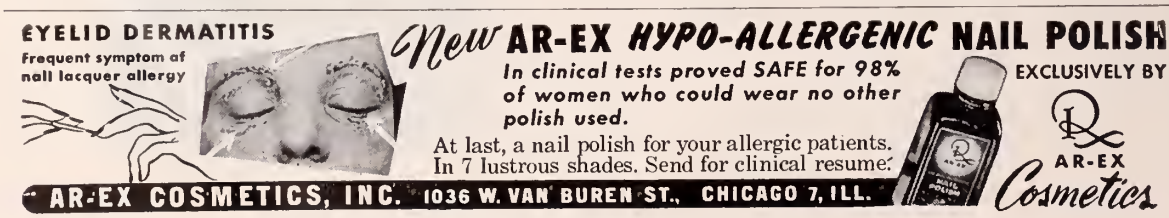
The author intersperses his listings with his own philosophical observations, most of them associated rather loosely with advice concerning preventive medicine. One is forced to assume, if he takes the book literally, that the chief disease entities to which the doctrines of epidemiology and preventive medicine must be applied are alcoholism and venereal disease.

His excursions into the fields of theology and religion would appear to be based on more substantial information to the uninformed layman; however, even in these fields it would seem to this reviewer that much of the reasoning lacks conviction. He has in my opinion exerted his best reasoning on a correlation of the first chapter of the Book of Genesis with the scientific facts contained in the various theories of evolution. However, even here the going becomes rough because of his habit of listing biblical references without then quoting them. There are portions of the book where as many as 25 references are listed merely as a series of numbers which refer to Bible chapters, paragraphs, and verses.

While the book might prove interesting to the student of theology, who is striving to correlate science and religion, I believe that even such a one would find most of its chapters fairly heavy going. To the physician in practice, I can see very little of value.—R.C.P.

Principles of General Psychopathology; An Interpretation of the Theoretical Foundations of Psychopathological Concepts. By Siegfried Fischer, M. D., clinical instructor in psychiatry, University of California; formerly professor of psychiatry and neurology, University of Breslau. New York, Philosophical Library, 1950. Price $4.75.

This book, as its title indicates, is concerned with the field of general psychopathology, and seeks to present a new interpretation of the facts of abnormal psychology. The author treats of each function of the mind—perception, thinking, memory, conscience, etc.—by defining and describing the function and presenting a brief description of its abnormalities. While the presentation is for the most part along fairly standard lines, the author varies considerably from traditional psychopathology in his views on consciousness, the clinical syndromes, and personality. The author's style, however, is so lacking in clarity, so discursive and repe-



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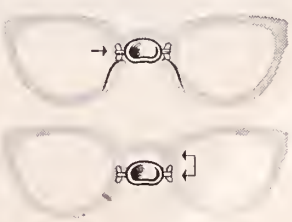

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titious, that it is frequently difficult to know just what his position is. One arrives at the end of a chapter having read a lot of words, but with no clear idea of what has been said or of its import. Careful re-readings of the text modify this impression but little. Although a new book in the field of psychopathology is certainly welcome, Doctor Fischer's book falls far short of meeting the need for a definitive and authoritative text on this subject.—O.O.

Methods in Medicine; A comprehensive Outline for Clinical Investigation, Management, and Treatment of Patients with Various Medical Disorders. By George R. Herrmann, M. D., Ph. D., professor of medicine, University of Texas Medical Branch at Galveston; director of the cardiovascular service and heart station, University of Texas Hospitals, consultant in medicine to the Surgeon General, U. S. Army; consultant in vascular diseases to the Marine Hospital, U.S.P.H.S. Second edition, completely revised. St. Louis, The C. V. Mosby Company, 1950. Price $7.50.

"The manual has been planned as a practical ward or bedside guide for the clinical investigation of the common and some of the more rare conditions. The methods are logically arranged and condensed, but with the retention of sufficient details for the execution of the method and the general interpretation of the results."

The reviewer is of the opinion that the above objectives, quoted from the preface, have not been achieved. This 480 page book is divided into 5 sections dealing with history taking and physical examination, clinical laboratory procedures, special clinical laboratory studies, therapeutic methods, and dietetic methods. It is apparent that with such a range of content the treatment of any particular subject is often superficial. The reviewer felt the lack of a critical approach to the laboratory tests: for example, when discussing the cephalin-cholesterol flocculation test (p. 275), the author states without qualification "It indicates a pathological process in the liver cells." When explaining the BSP test (p. 273), the author says, "Any disturbance of liver function or obstruction of the biliary passages would result in delayed removal of bromsulfalein from the serum." Normal values for hematocrit percentages in males are given on three separate occasions (pp. 42, 46, and 152), and each time different figures are quoted, and each time without reference to the literature. The sparsity of references is felt to be a distinct lack. The index is incomplete; only one page is listed under gastric hemorrhage though the subject is mentioned on at least three widely separated pages. The use of blood transfusions as a treatment for gastric bleeding is not mentioned on page 337, where the therapy of gastric hemorrhage is outlined.

This book is not recommended.—R.F.S.

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Immunology. By Noble Pierce Sherwood, Ph.D., M. D., F.A.C.P., professor of bacteriology, University of Kansas, and pathologist to the Lawrence Memorial Hospital, Lawrence, Kansas. Third edition. St. Louis, The C. V. Mosby Company, 1951. Price $8.00.

The Third Edition of Sherwood's Immunology differs from the second chiefly in the inclusion of new material introduced or emphasized in the publications of the last decade. Each chapter, as in the earlier editions, is accompanied by an extensive bibliography. We remain, however, with no adequate successor to Zinsser's "Resistance to Infectious Diseases" (or to the final edition, with Enders and Fothergill as collaborators.)

Sherwood still doubts the role of an antigen-antibody reaction in serum sickness, although he anticipates the eventual demonstration of such a basis for the tuberculin reaction. He pays minimal attention to the absolute quantitative method for the determination of antibody, to the lattice hypothesis, and to the use of complement fixation in the study of viral and rickettsial infections. Apparently he has overlooked the several papers reporting failure to confirm the prevention of histamine (and anaphylactic) shock by the use of histaminase. More understandably, he does not call attention to the more recent reports questioning the value *in vivo* and the actual nature of the so-called Rh haptene. One wonders why the author still uses the term "bacteriotropin", why he substitutes "suppression phenomenon" for Landsteiner's term "inhibition reaction", and, if it is not going too far, why he deals with the Felix–Weil instead of the well-known Weil–Felix reaction.

Persons who have used the second edition will undoubtedly use and recommend the Third Edition of Sherwood's Immunology.—F.E.H.

Paul Ehrlich. By Martha Marquardt. New York, Henry Schuman, 1951. Price $3.50.

This is the American reprint of a book published in England in 1949. The author, who was Ehrlich's secretary during the last 12 years of his all too short life, draws a most interesting and most charming portrait of one of the greatest figures in medicine of all times. Through "606" (arsphenamine) Ehrlich inaugurated specific chemotherapy, that is one of the most significant trends in contemporary medicine. A very readable and well illustrated book.—E.H.A.

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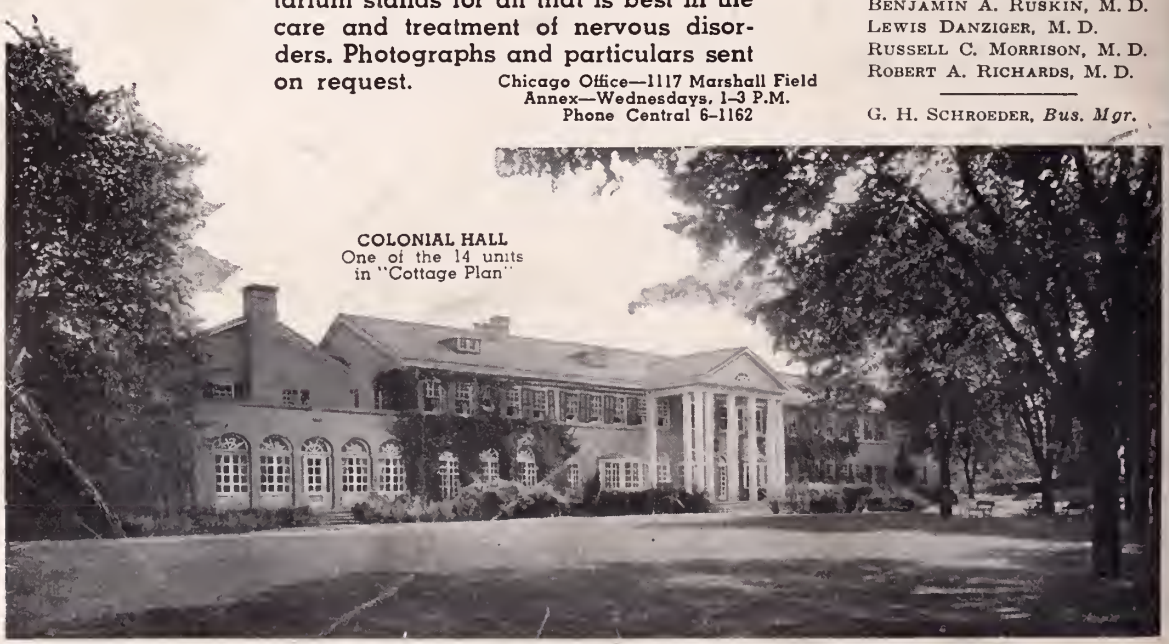

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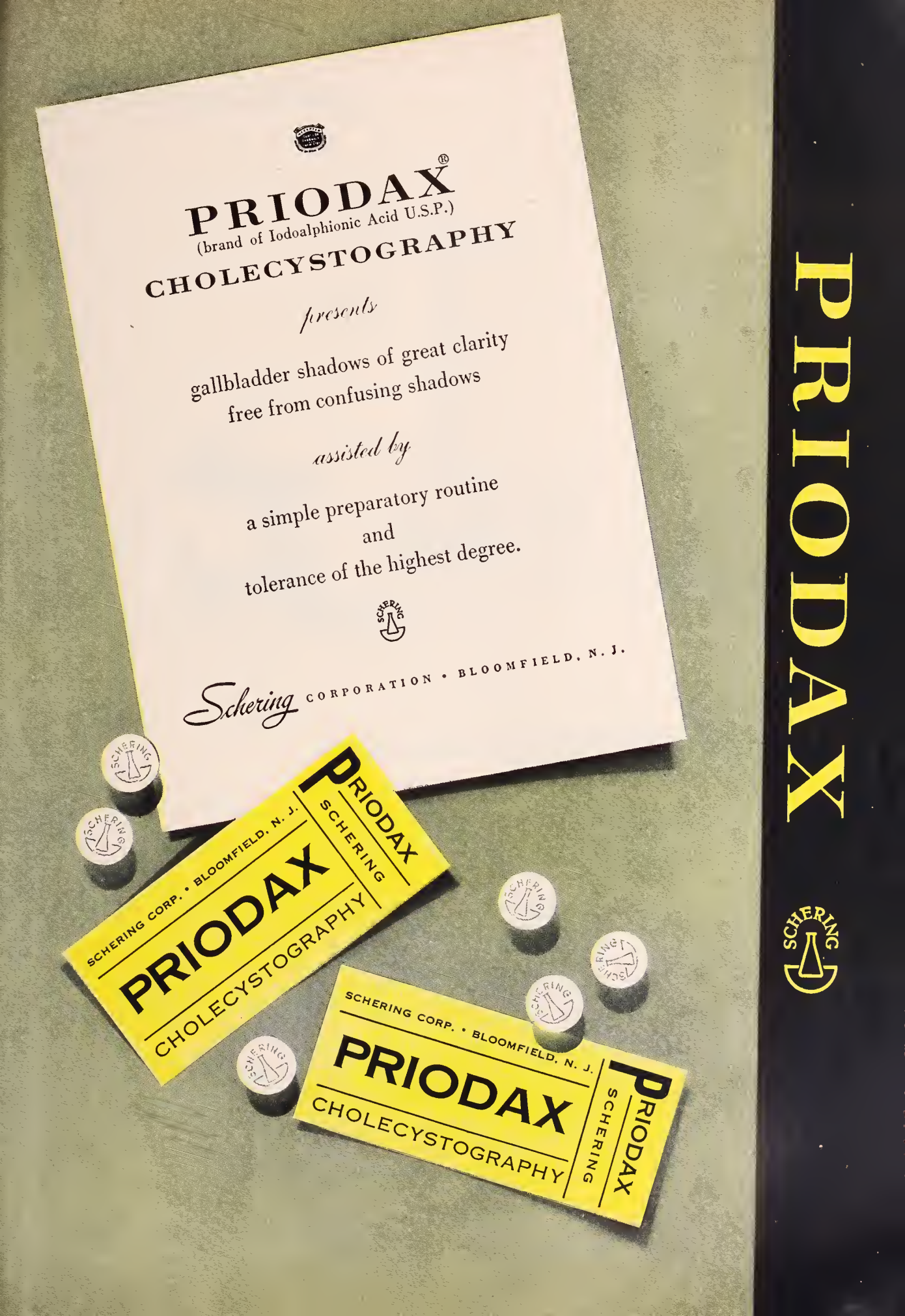
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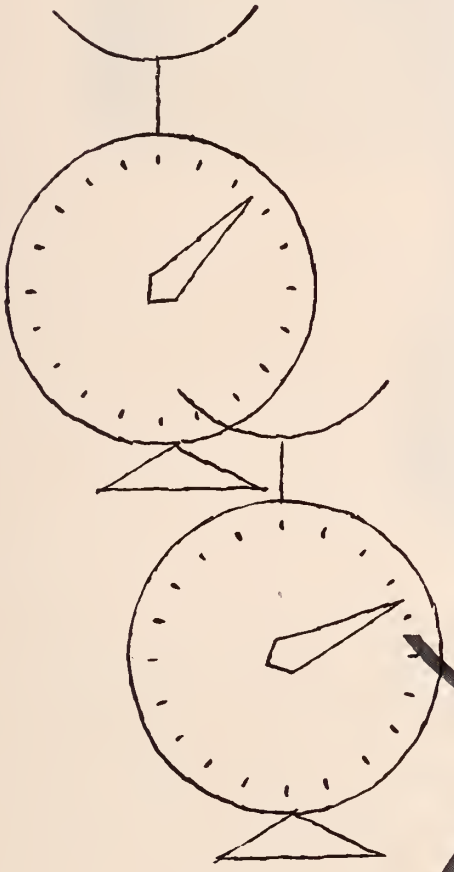

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1 Gardner, L. I., Butler, A. M., et al.: Pediatrics 5:228, 1950
2 Nesbit, H. T.: Texas State J. M. 38:551, 1943
3 Bull. National Research Council No. 119 Jan. 1950
4 Recommended Daily Dietary Allowances, Revised 1948, Food and Nutrition Board, National Research Council

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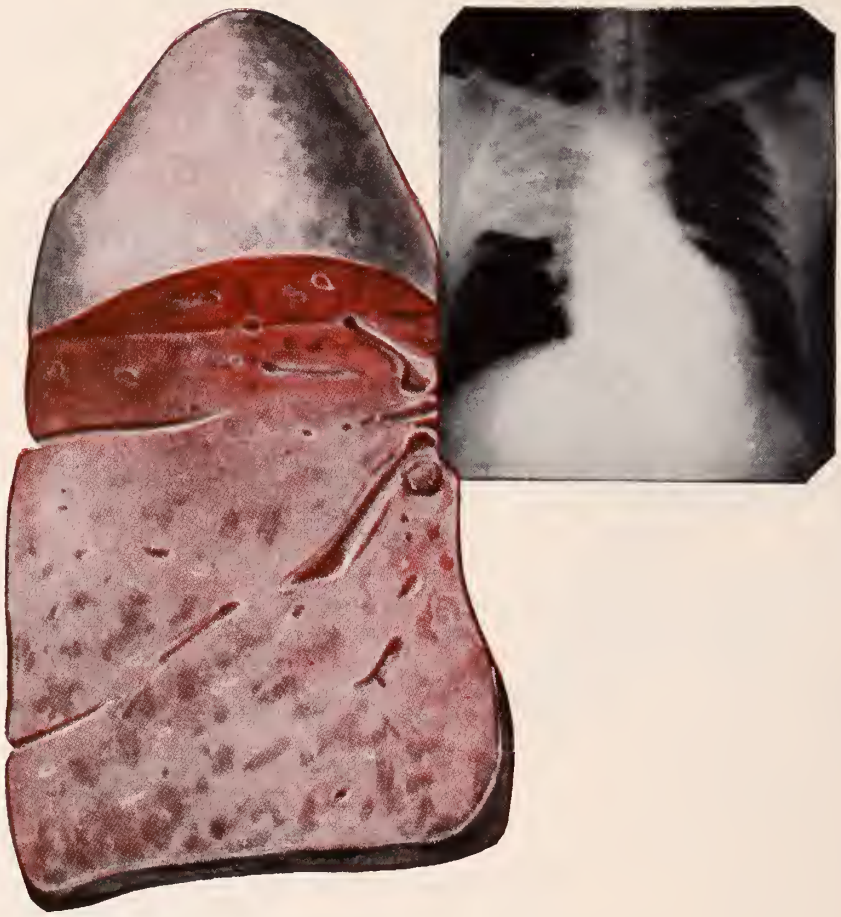

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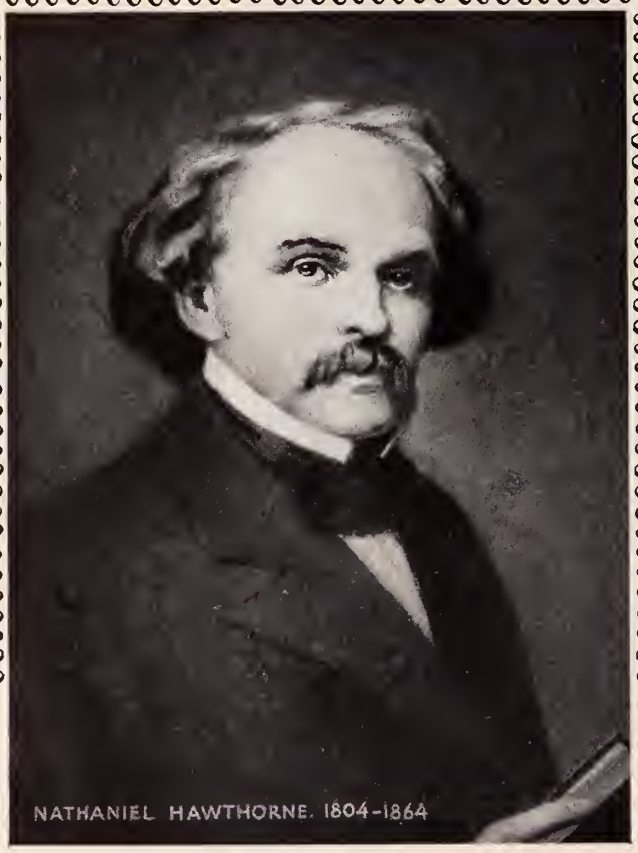

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**J.A.M.A. 146:35, 1951.*

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NORCROSS, B. M., *N. Y. State J. Med.* 51: 2356, Oct. 15, 1951.

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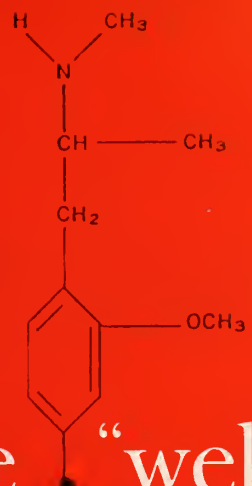

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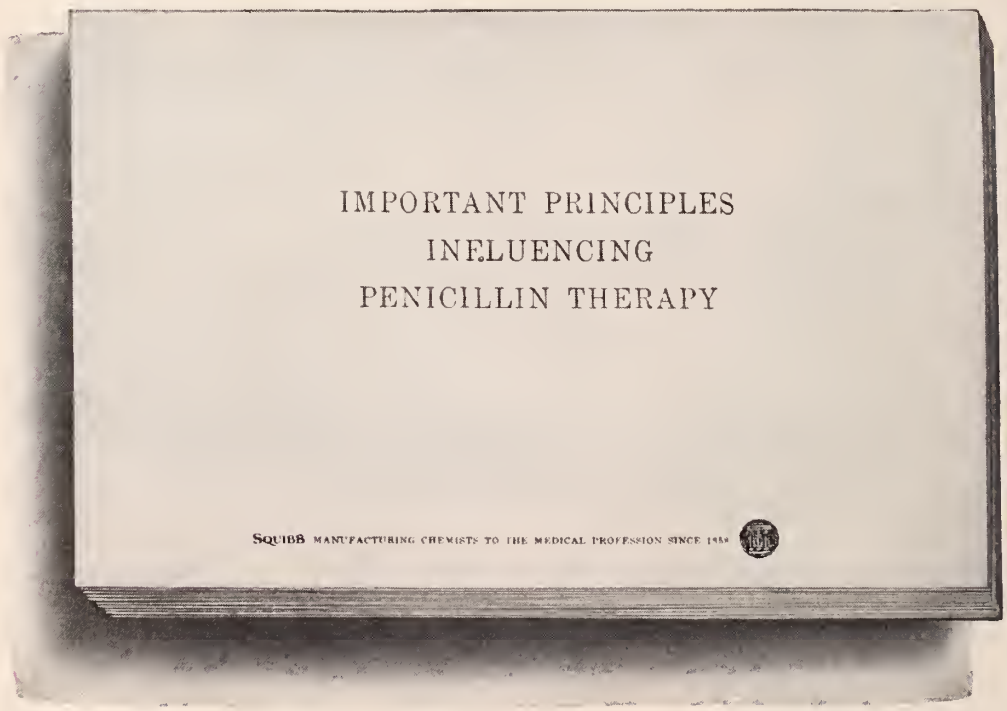

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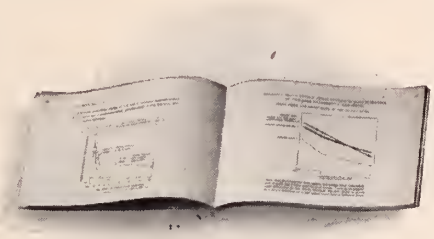

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« « « EDITORIALS » » »

Wisconsin's Pound Law*

A member of the aging generation that in its childhood sympathetically read the tale of Black Beauty, the horse, or of Beautiful Joe, the dog, has a nostalgic affection for the humane society that probably introduced him to these stories and in addition gave him a gold or silver star to wear in token of his regard for dumb animals. But he, in common with all other humanitarians, must also often feel chagrined that in the past thirty or forty years the humane societies have so frequently been used as a "front" behind which an intemperate and sometimes vicious campaign has been conducted against the eminently humane activities of medical investigators. Sensible persons are fully aware that the study of natural or induced disease in experimental animals results in better health not only for mankind but for animals as well.

Not all humane societies are guilty of furthering these campaigns. The Waukesha Humane Society of Wisconsin is apparently willing to cooperate with medical humanitarians and has given dogs to Marquette Medical School, two of which, Annie Okra and Nipper Okra, may go down in history because they have served in studies conducted at the school that led to the discovery that okra may be a blood-plasma substitute. Many other humane societies, however, behave as though they believed it more humane to kill all unwanted animals (they call it "putting them to sleep"). As a result, medical scientists struggle against needless obstacles, such as a lack of experimental animals, in their search for ways to control disease and pain.

Wisconsin is a progressive state, and its people voted in 1949 that unclaimed animals should be turned over to medical institutions for research studies. The state legislature has recently passed supplementary legislation providing that humane societies that fail to comply with the 1949 law shall become "immediately ineligible for any further public assistance or public funds from any county, city or village." Failure to comply with the law may also constitute grounds for revocation of the humane society's corporate charter, in accordance with the provisions of the bill signed by Governor Kohler on June 6.

It is to be hoped, and it is not unreasonable to expect, that the people of Massachusetts may ask for similar legislation here. When the humane societies can be brought to the realization that it is more humanitarian to save dogs from destruction so that they may be used in investigation aimed at helping persons, pets and livestock than to kill all homeless pets, they will have earned the wholehearted support of the medical profession.

*Reprinted from the *New England Journal of Medicine*, July 26, 1951.

Cobalamin*

Castle's experimental work indicated that an intrinsic factor secreted by the normal stomach reacts with a dietary extrinsic factor to produce an erythrocyte maturing factor which promotes red blood cell maturation in the bone marrow and which is essential for normal metabolism of nervous tissue. The major defect in pernicious anemia is the failure of production of intrinsic factor. The efficacy of whole liver in the treatment of pernicious anemia has been established for 25 years.

More recently pteroylglutamic (folic) acid and vitamin B_{12} have been shown to have hematopoietic activity in pernicious anemia. Folic acid is not the extrinsic factor nor the erythrocyte maturing factor. It does not seem to influence the central nervous system disorder. The citrovorum factor (folinic acid) which has been found in crude liver and yeast extracts is believed to be the biologically active form of folic acid, although its status is not established.

Vitamin B_{12} is one of a group of compounds for which the name Cobalamin has been proposed. B_{12}, B_{12a}, B_{12b}, B_{12c}, and B_{12d} have been isolated and all have the same type of biologic activity. Parenteral injection of Cobalamin solutions is an effective substitute for liver extract in the treatment of pernicious anemia. Cobalamin appears to be the extrinsic factor of Castle and in addition has many of the characteristics of the erythrocyte maturing factor. Vitamin B_{12} introduced into the marrow cavity stimulated red blood cell maturation while folic acid and citrovorum factor do not. Oral Cobalamin is efficiently utilized in pernicious anemia only if given together with a source of intrinsic factor.—Robert Yunck, M. D.

New Diabetes Journal

Diabetes, The Journal of the American Diabetes Association, a new publication to appear bimonthly beginning with the January–February 1952 issue, will be devoted to clinical and research reports on diabetes and related aspects of medicine. It will be the Association's official scientific and organizational publication, replacing its annual *Proceedings* and its quarterly *Diabetes Abstracts,* both of which have been published for the past ten years.

Diabetes will be edited by Frank N. Allan, M. D., of the Lahey Clinic, Boston, Mass., first vice–president of the American Diabetes Association. Doctor Allan will be advised and assisted by a distinguished editorial board under the chairmanship of Charles H. Best, M. D., of the University of Toronto, Toronto, Ont., co-discoverer, with the late Sir Frederick Banting, of insulin and its use in the control of diabetes.

According to Doctor Best, "The major purpose of *Diabetes* will be to give the medical profession and particularly the practicing physician information which will help him to improve the treatment of diabetes and allied disorders. The *Journal* will also be of interest to research scientists, since it will publish many of the important findings from the laboratories bearing on the problems of the disease. The scope of the *Journal* will be wide enough to include data dealing with all aspects of modern medicine that could have value for the physician interested in the therapy of diabetes or research in this field."

In addition to original contributions and scientific reviews, *Diabetes* will also include abstracts of papers dealing with diabetes that appear in scientific and medical periodicals here and abroad. This abstract section will help make the *Journal* an indispensable reference tool for both clinical and research physicians, since it will bring under one cover the latest information about the disease.

A variety of material of organizational and historical interest will also be included in the Journal, such as news of the clinical societies of the affiliate diabetes associations throughout the country, of which there are nearly thirty. A book review department will be a feature, as will the usual sections for correspondence, committee reports, and editorials.

The Case of the Reluctant Patient

Nothing is quite so important to adequate medical care as a feeling of mutual understanding between patient and doctor. It inspires a confidence that diffuses the fear, discomfort and inconvenience of illness, paving the way for effective treatment and rapid recovery. Most patients are as eager as physicians to achieve a high degree of rapport in this aspect of their relationship.

Yet it is not uncommon for patients to show a reluctance at bringing matters of fees, ethics and services into the same harmonious relationship. Physicians have long recognized that the fear occasioned by economic circumstances or inadequate knowledge of medical procedures may have a profound effect on the physical and mental well-being of the patient.

Your American Medical Association has designed an attractive office plaque to assist the "reluctant" patient and his unsuspecting physician in the achievement of a closer personal relation. It reads:

> To All My Patients
>
> I invite you to discuss frankly with me any questions regarding my services or fees.
>
> The best medical service is based on a friendly, mutual understanding between doctor and patient.

Order a plaque ($1.00 postpaid) today from your state medical society office. You'll find it will open the door to better relations with your patients.

*Prepared from "Facts About Nutrition," School of Nutrition, Cornell University, with confirmation or additional data from Bethell, et al: Cobalamin (Vit. B_{12}) and the Intrinsic Factor of Castle, Ann. Int. Med., September 1951.

Comments from the Wisconsin Press

"The Doctor's Looking Glass"

Comment on the Medical Press

This page is provided each month to serve as a sounding board on the attitude of the public press toward matters affecting medicine and the public health. Many newspapers run similar columns of quotes from other newspapers. This month the Wisconsin Medical Journal joined the ranks of the quoted when the Sheboygan Press, on February 4, 1952, reprinted in full the President's Page from the January Blue Book issue. Although public press comment on medical affairs is frequent, it should be of real interest to Wisconsin doctors that their "medical press" is widely read and often quoted by the public press.

* * *

"The Same Old Story"

"One of the greatest needs of the American people is a system of insurance that will enable them to pay doctor and hospital bills without going deeply into debt.

"Heading the fight against a national health insurance plan is the leadership of the American Medical Association (AMA). It has a hired team of press agents at $100,000 a year to manage the political campaign against the plan.

"So wild is the AMA in its opposition that it is trying to brand Republican Gov. Earl Warren of California as a Socialist.

"That's because Warren said it should be possible for every one of our people to protect himself and his family from the economic disaster of back-breaking hospital and medical bills. . . .

"It's the same old story. Whenever someone supports a program to help the people, he's a Socialist.

"It's all right to help the railroads, even through government subsidies. . . . It's all right to help the publishers, even through government subsidies.

"But it's terrible to help the people to set up a system of health insurance that they would pay for themselves. That's Socialism."—THE KOHLERIAN, Jan. 3, 1952.

* * *

Doctors' Grievance Committee

". . . The State Medical Society of Wisconsin was among the first to see the merit in the Colorado Plan (of grievance committees). The committee is made up of doctors from various parts of the state, of repute and influence in the profession, under the chairmanship of Dr. Robert E. Fitzgerald of Milwaukee.

"The committee works without fanfare, but is ready to give consideration to every written complaint against any Wisconsin doctor. Thorough investigations are made. Where the doctor is found to be in the wrong, remedial action is taken. . . .

"To the extent that the committee faithfully and fairly carries out its purposes, it serves the interests of both the public and the profession. The committee can strengthen public confidence that the profession in Wisconsin, as a whole, intends that the public shall get the best possible medical care at reasonable fees from all doctors.

"Without cost to the public, the Wisconsin society's grievance committee provides the machinery for better relations between doctor and patient, profession and public."—MILWAUKEE JOURNAL, Dec. 6, 1951.

* * *

Study of Hospital Costs

"An intensive two-year study of hospital costs and financing has been launched by the American Hospital Association. It will seek to find the best ways of supplying high quality hospital care at the lowest possible cost to the public.

"This is a worthwhile and timely project because of the vital role played by the hospital in the life of the individual, the community and the nation. Mounting costs of buildings, equipment and services at a time when demands on hospital facilities are greater than ever before have created pressing problems that are still far from permanent solution."—EAU CLAIRE LEADER, Jan. 29, 1952.

* * *

For Better Health Control

"In past months, there has been much behind-the-scenes delving into the operations of the city health department. In addition, the entire county health picture has been under review.

"In this connection, it was interesting to learn of the formation of a Community Health Council, not to attempt to dictate health policies, but to work in cooperation with city and county officials on an improved public health and sanitation program.

"We are convinced that a calm, impartial analysis and presentation of health and sanitation needs by a fair-minded committee will go far toward realization of goals.

"As to spending more money for health services in the years to come, taxpayers must accept that as inevitable . . . However . . . let's not be swept overboard financially."—KENOSHA NEWS, Jan. 30, 1952.

Ectopic Pregnancy

Report of Three Unusual Cases and Analysis of 83 Cases at Milwaukee Hospital

By F. J. HOFMEISTER, M. D. and C. A. HULTMAN, M. D.
Milwaukee

EXTENSIVE surveys of the problems of ectopic pregnancy show estimates that it occurs once for about every 177 live births,[1] and that it is responsible for 1.1 per cent of all gynecologic surgical operations.[2,3] The incidence at Milwaukee Hospital confirms these reports. During the six year period from January 1945 to January 1951, there were 83 patients with proven ectopic pregnancy and 15,643 live births, a ratio of 1 to 188. Of the 6,200 gynecologic surgical operations performed during that time, 1.3 per cent were for ectopic pregnancy.

The purpose of this paper is to present three unusual cases seen recently and to report the data from 83 cases treated by the hospital staff.

A pregnancy is called ectopic when nidation of the fertilized ovum occurs elsewhere than in its normal place in the endometrium. The most common ectopic site is the fallopian tube, though primary implantation is known to occur in either the ovary or the abdomen. As growth proceeds in the tube, the products of conception may be aborted into the abdominal cavity through the fimbriated end of the tube or directly through a rupture in the wall. Secondary nidation may then take place with development of an ovarian or abdominal pregnancy. Other more unusual ectopic sites are as follows: the broad ligament; the cervix; an endometrial pocket within the wall of the uterus which was the seat of adenomyosis; and the cul-de-sac in an area of endometriosis.[5] Twin pregnancies, one or both of which were ectopic, have occurred. The course and prognosis in any given case of ectopic pregnancy will be determined not only by the experience of the physician but also by the degree and severity of the symptoms produced as the fertilized ovum proceeds to its termination. Where there is early death of the embryo with complete absorption of the products of gestation, the symptoms may cause great concern to both physician and patient, though surgical intervention may not be distinctly indicated as determined by careful periods of close observation and evaluation. Indeed, there must be many such cases which are not even suspected, much less diagnosed! Without tubal rupture, the embryo may develop to an advanced stage before the symptoms send the patient seeking assistance, or less frequently, may go to term in a site of primary nidation. Following tubal rupture, an embryo may simply perish with no further symptoms, though it may continue development at the secondary site of implantation. There are a few instances in which the rupture changes the position of the embryo, but the placental attachment is not disturbed, and the development continues in the primary site.[6] In the summary of 1,225 cases from nine authors, Jarcho[7] lists only 5 ovarian, 5 broad ligament, and 17 abdominal sites of implantation, or an incidence of only 2 per cent of unusual ectopic pregnancies.

Etiology

Tubal defects are generally considered the most important factors in producing ectopic pregnancy. These defects may be the result of inflammatory reactions, congenital anamolies, previous ectopic pregnancy, or previous pelvic operations. Previous abortions are also believed to be factors. Attention has recently been directed to the possibility of a nutritional factor[8] whereby a profound defect in metabolism affects changes in the pelvic physiology so as to involve not only the germ plasm itself but also the pelvic transportation system.

Only 4 cases in our series had underlying tubal pathology, 2 of which were the result of previous operative tubal ligations. Twenty-seven gave a history of previous abortion or miscarriage; 3 had had a previous ectopic pregnancy on the opposite side.

Symptoms and Course

As nidation may take place in the ovarian follicle, the tubal pathway, the parietal peritoneum, or remnants of pelvic organs remaining after previous gynecologic operations, so may the clinical course of ectopic gestation vary from the typical symptom complex of the "catastrophe" to the bizarre clinical pictures presented by the many atypical forms.

Falls[9] believes our textbooks and many papers on this subject are actually misleading, since they stress the dramatic picture following acute rupture almost to the exclusion of a large number of cases in which no such picture is present.

TABLE I

	Authors	Jarcho[7]	Word[10]
Number of Pregnancies	83	173	140
Symptoms (per cent)			
Abdominal pain	80	88.4	97.8
Irregular bleeding	68	73	90.7
Amenorrhea	33	73	62.8
Pelvic mass		51.4	57.1
Abdominal tenderness		48	92.8
Weakness and faintness		47	

Observations of our cases confirm those of Jarcho[7] and Word[10] in which the most commonly recorded signs and symptoms of ectopic pregnancy are abdominal pain and tenderness, and irregular vaginal bleeding. However, a history of amenorrhea is elicited in only one-third of our cases as compared to at least double that number for Jarcho and Word.

Diagnosis

The typical case of ruptured ectopic pregnancy with its dramatic sequence of events usually presents no diagnostic problem. But those who look only for this clinical picture many times will leave for others the discovery of the condition, perhaps at autopsy. The symptoms of atypical forms may be so vague and confusing that the correct preoperative diagnosis can only be guessed. These atypical cases, which comprise almost half, are a real challenge to one's diagnostic ability. But in many of them a further period of observation and the utilization of additional diagnostic aids will often reveal the true nature of the condition.

Some of the experience at our hospital might be cited to illustrate the diagnostic difficulties encountered. Two patients previously had been sterilized by tubal ligation. Another previously had an operation for suspected ectopic pregnancy. A hemorrhagic cyst of the ovary was found. About 18 months later her symptoms of irregular vaginal bleeding and abdominal cramps recurred. Pelvic examination under anesthesia was negative, and a dilatation and curettage revealed a follicular endometrium. Two and one-half weeks later she again developed pain, vaginal bleeding, nausea, and vomiting. Her abdomen was tender, and the left ovary was palpably enlarged. The surgeon performed a laparotomy and discovered an acute salpingitis on one side and a ruptured tubal pregnancy on the other.

Twenty per cent of our patients were operated on by general surgeons, many of whom made a preoperative diagnosis of appendicitis or a complication thereof.

In order to diagnose ectopic pregnancy, one must think ectopic pregnancy. Early diagnosis and prompt treatment prior to rupture with shock and hemorrhage have markedly reduced the mortality of these cases, although the freer use of blood, blood substitutes, and antibiotics is also important. Most of the missed and delayed diagnoses are due to misinterpretation of the symptoms by the patient as well as the doctor.

Allen[11] summarized some of the reasons for faulty diagnosis as follows:

1. Women are so notoriously inaccurate concerning their menstrual function that they are unaware that the bleeding is abnormal in character, since it frequently occurs at or near the time of the next expected menses and is usually not profuse.

2. Ectopic pregnancy occurs frequently in women previously sterile for long periods and those around 30 years of age who have ceased keeping a menstrual calendar.

3. Patients in general do not seek medical advice unless they have pain, and the early discomfort of extra-uterine pregnancy is often mild and resembles gas pains. It is often interpreted as such even by the physician until the pain of tubal rupture or shock of hemorrhage occurs.

Allen's[11] diagnostic "rules of thumb" are well worth emphasizing.

1. Any patient who complains of irregular bleeding is to be suspected of having pregnancy or malignancy until proven otherwise.

2. The shorter the period of amenorrhea preceding the onset of bleeding, the more likely is the nidation extra-uterine.

3. The more profuse the bleeding, the more likely it is to be intra-uterine.

4. The greater the number of presumptive signs and symptoms of pregnancy, the more probable that it is intra-uterine.

5. Anemia more profound than can be reasonably accounted for by history of external blood loss indicates concealed hemorrhage into the peritoneal tissues or cavity.

6. Central lower abdominal pain comes with uterine expulsive efforts, while unilateral discomfort is more likely to be tubal in origin.

7. Fainting is rarely caused by the efforts of uterine expulsion any more than labor produces syncope at term. The pain caused by distention of the parietal peritoneum by even small quantities of extravasted blood may cause repeated loss of consciousness.

8. Shoulder pain with or without jaundice associated with metrorrhagia indicates pelvic bleeding rather than stones in the gall bladder. Slight jaundice in a patient with suspected ectopic pregnancy is almost pathognomonic of intra-uterine abdominal pregnancy.

9. The external and internal bleeding associated with ectopic pregnancy may begin on or before the next expected period.

10. A history of marriage is not essential for the diagnosis of ectopic pregnancy.

Additional diagnostic procedures of value in the more difficult cases include biologic tests for pregnancy, hysterosalpingography, peritoneoscopy and culdoscopy, puncture and aspiration of Douglas' pouch, posterior colpotomy, and dilatation and curettage. The biologic tests for pregnancy are of limited value, since a negative result may only mean the test was done too early to be significant, or too late after tubal abortion and fetal death. A positive test may give a clue in the obscure and atypical case, but it takes too much time to be of value in the acute case.

Many writers[12–14] mention cul-de-sac puncture only to condemn it in favor of posterior colpotomy, since they argue that, having made an accurate diagnosis by the latter method, it is simpler to continue via the vaginal approach and remove the offending tube and its contained ovum. Of the 13 patients upon whom a colpotomy or cul-de-sac needling was performed, only 2 had vaginal removal of the ectopic pregnancy.

In 26 per cent of the patients a preliminary dilatation and curettage was done, but in some instances these were done for what was diagnosed as a threatened or incomplete abortion, and the final laparotomy was not done until several days or even weeks later. It is in these cases that a colpotomy

would reveal the true diagnosis and permit immediate treatment.

In Word's[10] 140 cases a cul-de-sac puncture was the most consistently positive diagnostic test (51 of 53 cases done), and no other laboratory test for ectopic pregnancy has been proved correct in as high a percentage of instances. He found the test simple, harmless, and only slightly more difficult than drawing blood from the vein of an extremity. In Word's report, hospital residents had performed this test in the emergency room on any patient suspected of harboring a ruptured ectopic pregnancy, and in 5 years of its extensive use by the house staff, there had been no complications. Blood in the peritoneal cavity was found at laparotomy in 127 of the 140 cases, and if this simple test had been done in all instances, the correct diagnosis would have been facilitated in 90 per cent of them. Like any other diagnostic aid, cul-de-sac puncture needs intelligent interpretation.

Treatment

Physicians who have had considerable experience with this condition advocate operation as soon as the diagnosis is made. Approximately one-half of the patients in this series had an unruptured tubal pregnancy at the time of operation. Judicious use of whole blood and other fluids intravenously will combat shock, and will put the patient in safe condition for operation.

The ectopic pregnancy should be treated by removing such structures as are damaged, after the intra-abdominal bleeding is controlled. The tube alone should be removed and the ovary conserved, unless it is involved and damaged beyond repair. Because of the increased incidence of recurrent ectopic gestation following partial tubal resection, it is advised that the entire tube be removed. Additional surgical procedures to correct existing abnormalities or prevent future illnesses are only performed after the condition of the patient has been evaluated. Additional procedures are always dependent upon the judgment and skill of the operating surgeon. Allen[11] stresses that removal of the opposite tube to prevent a subsequent ectopic pregnancy is unjustifiable unless other conditions are present for which sterilization is indicated.

In our series 36 per cent had only one tube removed, 18 per cent had the tube and ovary removed, and 15 per cent had the tube removed with either resection of the opposite ovary or an incidental appendectomy. The remaining 30 per cent of the patients had more extensive surgical treatment performed, when indicated, including one total and four subtotal hysterectomies.

Complications

Relatively few postoperative complications occurred. One patient in 1945 had a slight postoperative vaginal bleeding, mild ileus, and probably a pelvic abscess or localized peritonitis. In 1947 there was 1 case of partial wound disruption and 1 of slight wound infection. Complications other than these have been limited to a few cases of febrile morbidity, as defined by the American College of Surgeons. Each year there has been an increasing number of individuals receiving transfusions as well as more blood being used per person. In the first three year period of this study, there were only eight transfusions of a total of nine pints of blood given in 44 patients. During the last three years, 15 transfusions gave 46 pints in 39 patients. The only maternal death in our series was reported previously.[15] The patient had a full term abdominal pregnancy and died from an embolic reaction on the twenty-fifth postoperative day, while she was on the bed pan.

Allen[11] cites reports from various parts of this country which show that one-third of all deaths from hemorrhage are due to extrauterine pregnancy. In 1947 the mortality for ectopic pregnancy was estimated at 5 to 10 per cent.[16] Word now estimates it at 1.5 per cent.[10] For our series at Milwaukee Hospital it was 1.2 per cent. From 1936 to 1948 the number of deaths in the United States from ectopic pregnancy was reduced from 486 to 243, while the number of live births was increased 64.8 per cent.[17] Thus there was actually a reduction in the mortality rate of almost 70 per cent (22.65 to 6.87 per 1000).

The Unusual Forms

Most ectopic pregnancies have a fairly typical clinical course, but in a considerable number of patients the manifestations are bizarre, either because the site of implantation is unusual or because of the coexistence of another pregnancy.

Eleven of our patients had 12 unusual sites of implantation, an incidence of 13.25 per cent. In this group were two cornual, two ovarian, two extra and intrauterine, one compound bilateral, and five abdominal. One of the intra and extrauterine and two of the abdominal pregnancies have been reported earlier.

The patient who had a simple cornual pregnancy gave a history of vaginal bleeding for six weeks. She was treated with a subtotal hysterectomy.

One of the patients with an ovarian pregnancy was operated on because of an episode of acute pelvic and shoulder pain. An ovarian hematoma was removed and the pathologist found that it contained a pregnancy.

In one of the patients with an abdominal pregnancy, the site of implantation was the cul-de-sac, and in a second patient implantation was the external surface of a fallopian tube. In a third, the site was the external surface of the tube 1 cm. from the cornu of the uterus, where it had eroded the ovarian artery producing the signs and symptoms of acute tubal rupture with extensive hemorrhage. The patient entered the hospital in shock.

Report of Cases

Detailed case reports of the other 3 patients with unusual sites of implantation follow:

CASE 1.—*Intra- and Extra-uterine Pregnancy.* A 30 year old nullipara, whose last menstrual period had been October 27, 1949, spotted in late November. She was given 5 mg. of stilbestrol four times a day, and on December 27, sudden severe abdominal pain developed, radiating up to the diaphragm and shoulder, with associated dyspnea. The uterus was the size of a seven to eight weeks pregnancy, and the patient appeared very pale, as with intra-abdominal hemorrhage, although the pulse was normal. The right adnexal area was highly sensitive, but no masses were felt.

The preoperative diagnosis was intrauterine pregnancy with ruptured extrauterine pregnancy and hemorrhage.

Exploratory laparotomy was performed, and a ruptured right ectopic pregnancy was found in about the mid portion of the tube. The right tube was removed in its entirety except for the cornu, because it was believed that the uterus contained a live fetus.

The pathologist reported ectopic tubal pregnancy. Stilbestrol was given postoperatively in 25 mg. doses by injection until it was tolerated orally and thereafter four times a day. Proluton was given in 25 mg. doses and then twice a day. A pint of blood was administered by transfusion, and prophylactic penicillin was given for a few days. The stilbestrol medication was stopped at the end of five months gestation. A normal male was born July 28, 1950.

Comment: Combined extrauterine and intrauterine gestation implies the coexistence of relatively simultaneous pregnancies, rather than the superimposing of an intrauterine pregnancy upon a pre-existing extrauterine pregnancy, commonly called compound, even though the extrauterine fetus may have been dead or in lithopedion form.

Not more than 420 cases of combined intrauterine, extrauterine pregnancy have been reported. Unquestionably, there are many cases not recognized and others recognized but not reported.

The symptoms of the ectopic pregnancy usually bring the patient to the physician, and the presence of the intrauterine gestation frequently is not suspected at the time of operation. The prognosis is good for the intrauterine gestation in patients with this type. Unfortunately, some patients abort the intrauterine pregnancy early, and later develop the signs of an ectopic pregnancy, ruptured or otherwise. Maternal mortality is higher among these patients if early diagnosis is not made and if they are given too vigorous a pelvic examination. In the past many of these were found at autopsy, so that the maternal mortality was close to 19 per cent,[18] but with modern surgical treatment and care, it is estimated to be at 1.5 to 2 per cent. Michaels,[19] in reporting 4 cases, states that in only 2 cases was the diagnosis made or even suspected at operation. In both of them the corpus luteum was unfortunately sacrificed and only one continued to term, while the other aborted three weeks postoperatively. In this type of case, substitution therapy with hormones might be of value in protecting and prolonging gestation.

CASE 2.—*Bilateral Tubal Pregnancy.* A 24 year primipara whose last menstrual period had been Feb. 20, 1950, was first seen one week after the last menses. The patient stated the period stopped and started again and thereafter she spotted. Pelvic examination was negative. When spotting was not controlled with Ergotrate, the patient was put on 5 mg. of stilbestrol twice a day for five days. The patient did not return to the office until April 4, four to six weeks later. She had spotted intermittently since February and had had no period in March. She was then placed on thyroid and stilbestrol, and examination at that time revealed a left ovarian enlargement. A tentative diagnosis was made of possible ectopic pregnancy or ovarian cyst.

Five days later she was again seen, and a note was made of uterine enlargement and the persistence of left ovarian enlargement. When she was seen one week later, she complained of increased vaginal bleeding and pelvic pain. A positive Friedman test had been obtained since her last office visit.

An operation was performed that afternoon, and an unruptured ectopic pregnancy of the left tube was found which also involved the ovary. Another ectopic pregnancy was found at the right cornu, with complete separation of the tube from the uterus, without excessive bleeding, probably as the result of the examinations under anesthesia just prior to laparotomy. Neither tube could be saved, so what amounted to a bilateral salpingo-oophorectomy and subtotal hysterectomy was performed, as well as a prophylactic appendectomy. Her postoperative course was uneventful.

The pathology report was (1) ancient ectopic pregnancy involving right cornu of uterus; (2) recent ectopic pregnancy of left fallopian tube; (3) endometrial implants in the lower uterine segment; and (4) fibrosed appendix.

Comment: Bilateral tubal pregnancy is less common than intra and extrauterine gestation. By 1945, 94 cases[20] had been reported in the literature. The case we report here makes six that have been added to the literature since then. The diagnosis has never been made preoperatively. Careful examination of the tube on the opposite side from the one involved at the time of operation is of the greatest importance. Failure to do so can lead to a tragic result.

CASE 3.—*Ovarian Pregnancy.* This 41 year old nulliparous woman gave a history of normal menses in April. After two months of amenorrhea and a positive Hogben test in June, the patient bled for two and one-half days in July and spotted in August and September. She reported having a "normal" menstrual period one week prior to operation on Oct. 27, 1950. Although her uterus had originally been enlarged to the size of a two to three months preg-

nancy, it had gradually regressed in size, but a persistent left adnexal mass was noted, which pushed the uterus to the right. The preoperative diagnosis was missed abortion complicated by uterine fibroids. A dilatation and curettage revealed some degenerated material. When the abdomen was opened, a large mass was found at the site of the left ovary. This was enucleated, separated from the ovarian ligament, and removed along with the left tube. The left side was explored carefully and no damage to the ureter was found. Inspection of the right tube and ovary revealed a hematosalpinx buried in the cul-de-sac. Because of the destruction of this tube, and an apparently poor ovary, both structures were removed. Total hysterectomy and prophylactic appendectomy also were performed.

Pathologic diagnosis was (1) ectopic pregnancy in left ovary; (2) hematosalpinx, right; (3) uterine adhesions; (4) fibrosed appendix; and (5) serosal cyst of the appendix.

Comment: Ovarian pregnancy is probably not so rare as the relatively small number of reported authentic cases would indicate. Although its possibility was first suggested in 1614, it was not until 1899 that the first authentic case was reported. To date some 200 cases have been recorded, but only a little more than 60 of these fulfill the necessary criteria originally established by Spiegelberg in 1878. These are as follows:

1. There must be an intact fallopian tube on the affected side, not connected to the gestation sac.

2. The gestation sac should occupy the position of the ovary.

3. The gestation sac must be connected to the uterus by the ovario-uterine ligament.

4. The sac wall must contain definite ovarian tissue in several positions at some distance from each other.

Ovarian pregnancies may be either primary or secondary. In the primary type, there is fertilization and nidation of the ovum in a ruptured graafian follicle, while in the secondary type there is an external implantation and development of a previously fertilized ovum. The history of sterility previous to the pregnancy suggests that interference in ovulation may be a factor in making the ovary the site of implantation. Due to such structural changes as fibrosis or thickening of the tunica albuginea or changes in the tension of the liquor folliculi, the ovum does not leave the follicle after rupture and usually perishes there, except where fertilization takes place within the follicle. The fertilized ovum makes good use of the vascularity of the ovary, and although the process of development may erode blood vessels and cause a hemorrhage fatal to the fetus, nevertheless, gestation proceeds farther than in the tubal type of ectopic gestation. A number of full term ovarian pregnancies have been described.

Summary

1. Eighty-three cases of ectopic pregnancy at Milwaukee Hospital are reviewed and compared with previously reported surveys of this condition.

2. Three unusual cases of ectopic pregnancy are reported:

   a. Combined intra and extrauterine pregnancies.
   b. Bilateral tubal pregnancy.
   c. True ovarian pregnancy.

3. The method of management of the three unusual cases is reviewed.

4. Caution and care are emphasized in the use of procedures for diagnosis and treatment of ectopic pregnancy.

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Comparative Evaluation of a New Oral Cholecystographic Agent (Telepaque)* with Priodax

A Preliminary Report

By JEROME L. MARKS, M. D.[1], and JAMES A. SCHELBLE, M. D.[2]

Milwaukee

Purpose of Study

THIS study was undertaken to determine the effectiveness of a new cholecystographic agent 3-(3-amino-2, 4, 6-triliodophenyl)-2-ethyl propanoic acid (Telepaque),[1,2] and to compare this new agent with the conventionally used iodoalphionic acid (Priodax). The patients in this series had two cholecystographic examinations under the same conditions at intervals of three to five days. Telepaque was used for one examination and Priodax was given for the other examination as a basis of comparison. It is believed that a comparison study between the two agents in the same individual affords an excellent method of evaluation.

Method of Study

Patient Group.—Fifty patients suspected clinically of gallbladder pathology were examined. Eleven were males and the remaining 39 were females. The average age was 60.9 years. The youngest patient was 25 years of age, and the oldest patient in the group was 80.

Administration.—The patients were divided into groups of 25. The first 25 received Telepaque for their initial examination, and subsequently in three to five days received Priodax. The remaining 25 received the Priodax first, followed in three to five days by Telepaque. This was done to eliminate the possibility of a cumulative effect from either cholecystopaque.

Dosage.—Both agents (Telepaque and Priodax) were given in amounts of six tablets (3 Gm.) orally following the standard fat-free meal in the evening prior to the roentgenographic examination. The roentgenograms were taken 14 hours after the administration of the dye. Roentgenograms were also taken following the administration of a fatty-meal.

Results of Study

Both agents (Telepaque and Priodax) gave equal results in 34 of the 50 patients examined. In the remaining 16 patients different results were obtained with the two agents. Telepaque revealed superior visualization in 13 patients, and Priodax was better visualized in the remaining 3 patients of this group. The usual precholecystographic preparation was employed for both agents. Side effects and systemic toxicity were carefully recorded during the examinations. Unfavorable toxic manifestations from either agent occurred in less than 20 per cent of the patients and were very mild in nature. These findings compare closely with the recent report on Telepaque by Christensen and Sosman.[3] These reactions consisted principally of nausea and occasionally a moderate diarrhea. For standardization of interpretation the intensity of gallbladder visualization was indexed. The method utilized was suggested by other authors,[1] and provided a simple method of comparison. The index is as follows:

CHART I

Cholecystographic Index	Description
4	**Excellent.**—A sharp outline of the gallbladder with sufficient intensity to make the gallbladder stand out in brilliant contrast with the surrounding tissues.
3	**Good.**—A distinct shadow of the gallbladder with satisfactory intensity and good definition.
2	**Fair.**—A faint shadow of the gallbladder with faint but visible definition.
1	**Poor.**—Faint evidence of gallbladder concentration as shown by an area of increased density in the region of the gall bladder, but with no definition.
0	Non-visualization.

The results of the differences obtained using the above index are listed in Chart II.

* Material supplied through the courtesy of the Department of Medical Research, Winthrop–Stearns, Inc., 1450 Broadway, New York 18, New York.

[1] Director, Department of Radiology, Milwaukee County Hospital. Assistant Clinical Professor in Radiology, Marquette University School of Medicine.

[2] Senior Resident, Radiology, Milwaukee County Hospital. Teaching Fellow in Radiology, Marquette University School of Medicine.

CHART II.—*Cholecystographic Results*

	Patient No.	Telepaque	Priodax	Pathology Demonstrated
Telepaque Superior	1.	3	0–	Normal, Telepaque Non-visualization, Priodax
	2.	3	0–	Normal, Telepaque Non-visualization, Priodax
	3.	3*	1	Cholelithiasis, Telepaque Not diagnostic, Priodax
	4.	4*	2	Non-opaque calculi
	5.	4	2–	Cholelithiasis
	6.	4*	3	Cholelithiasis
	7.	4	3–	Normal
	8.	4	3–	Normal
	9.	4	3–	Cholelithiasis
	10.	3*	2	Adhesions
	11.	3*	2	Non-opaque calculi
	12.	2	1–	Mixed calculi
	13.	1*	0	Mixed calculi
Priodax Superior	14.	1*	3	Non-opaque calculi
	15.	3*	4	Non-opaque calculi
	16.	3	4–	Normal
	17–50	Equal results (34 cases)		Normal, 12 cases Non-visualization, 14 cases Phrygian cap, 2 cases Adhesions, 1 case Opaque calculi, 3 cases Non-opaque calculi, 2 cases

*Telepaque administered on initial examination.
–Priodax administered on initial examination.

Summary

Cholecystographic examinations were carried out on 50 patients comparing a Telepaque series with a Priodax series in the same individual. In 34 patients both agents gave equal results. Telepaque proved superior in 13 of the remaining 16 examinations. In 2 of the 13 cases, Telepaque revealed a normally visualized gallbladder that failed to visualize with Priodax and would have been diagnosed as a pathologic non-visualization with this latter agent. In 1 of the 13 cases, the diagnosis of cholelithiasis was made using Telepaque. In this same patient, the Priodax examination revealed only a faint gallbladder shadow that was not diagnostic. The remaining differences were in degree of cholecystographic intensity and did not alter the diagnosis.

Conclusion

In 47 (94 per cent) of the 50 patients examined by the comparison method, Telepaque proved equally as good in 68 per cent of the cases and superior to Priodax in 26 per cent of the cases studied.

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NATIONAL CONFERENCE ON OBSTETRICS AND GYNECOLOGY TO BE HELD AT CINCINNATI

The Fifth National Congress on Obstetrics and Gynecology is to be held in Cincinnati, Ohio, on March 31 through April 4. The program will coincide with a meeting of the newly formed American Academy on Obstetrics and Gynecology, it was announced by Ralph E. Campbell, M.D., Madison, district governor for Wisconsin and neighboring states.

Highlights of the five day session will include a report of a monumental study of 10,000 neonatal deaths recently completed in Chicago. The report will be given by Doctor Herman H. Bundesen, president of Chicago's Board of Health and a former president of the American Public Health Association; Doctor Edith Potter, University of Chicago, who will describe the autopsy procedure; Mr. Frank Bauer, bio-statistician of the Chicago Board of Health; and Doctor William Fishbein, who will describe the epidemiologic approach to the problem and the analysis made of the tabulated data.

Other important features of the meeting will include a series of panels on nursing problems, a report from Joseph Lawrence, M.D., head of the A.M.A. Washington Office on "Proposed E.M.I.C. Legislation", and other parts of a special program which will discuss the educational, social, economic, and political phases of medical practice.

Doctor Campbell reports that special sessions of the American Academy will be held to discuss organizational matters and to expand the facilities of the Academy to its members.

Full information on the details of the program can be secured by writing The American Committee on Maternal Welfare, 116 South Michigan Avenue, Chicago, Ill.

Highlights in the Diagnosis and Treatment of Some Common Ear, Nose, and Throat Conditions

By IRVING MUSKAT, M. D.
Milwaukee

Introduction

THE antibiotics have by no means solved the problem of ear, nose, and throat infections. Although most of these infections respond in a gratifying manner, some do not, and grave dangers await the patient whose doctor overlooks the signs of a spreading process, and who fails to recognize the indications for surgery. The need for surgery has not yet been eliminated by antibiotics. It is true that penicillin and its allies have greatly decreased the number of mastoid, sinus, and other complications, but it is also true that the injudicious use of these drugs has provoked trouble in many patients. Their masking effect has so complicated the problem of diagnosis that only by the exercise of the utmost caution can patients escape unfortunate complications. Acute pernicious middle ear infections may progress unnoticed to an intracranial complication if the offending organisms do not respond to the particular antibiotic used or if the pus becomes imprisoned. Brain abscess, septic meningitis, and lateral sinus thrombosis have occurred under these circumstances.

Most of these complications can be avoided if bacteriologic studies are made to select the most effective preparation whenever response to the antibiotic is not satisfactory, and if surgical drainage is instituted whenever the signs of an unyielding purulent focus persist.

Acute Purulent Otitis Media

Middle ear infections due to the pneumococcus type III organism are particularly dangerous because of their insidious onset and because the clinical features do not reflect the seriousness of the pathologic process. Intracranial complications can be expected when resolution is not rapid. The mortality rate from type III pneumococcus meningitis is practically 100 per cent without antibiotics and surgical drainage of the original focus. It is 80 per cent when antibiotics alone are employed. Early mastoidectomy and antibiotics can prevent intracranial involvement in many cases. The operation must completely remove the mastoid focus, exposing the middle and cranial fossae, to insure removal of all avenues through which the infections might travel to the meninges and brain. The operation is indicated even if meningitis has already developed, but we must expect a mortality rate of about 15 per cent.

It is important to know that every case of acute purulent otitis media is associated with involvement of the mastoid cells, the extent and progress of which depends upon the severity of the infection, the cellular structure of the mastoid, and the individual immunity. Clouding of mastoid cells, seen on x-ray, is not of itself an indication for surgery, for the mastoid cells are involved in all patients with acute purulent otitis media. But, whenever there is evidence of bone destruction the need for surgery is urgent.

Chronic Purulent Otitis Media

An acute middle ear infection which does not clear up after six weeks often becomes chronic. Removal of the infecting focus in the nose and throat, or surgical mastoid drainage, may terminate the process and prevent chronicity. Whether an acute middle ear infection resolves under ordinary measures or becomes chronic depends upon the kind of organism, the type of mastoid cells, the amount of infection of the tonsils, adenoids, sinuses, or bronchi, and the general resistance of the individual. Chronic middle ear infection means continued suppuration, loss of hearing, and the everlasting threat of intracranial involvement. Some patients complain only of a "moist" ear and of a slight decrease in hearing, and they may have only a small attic perforation. The mildness of these symptoms and signs obscures the seriousness of a situation that may flare-up and go on to intracranial involvement following any acute upper respiratory infection.

Secretory Otitis Media

Acute secretory otitis media, often called acute middle ear catarrh and which is more frequently seen in children than in adults, is due to the accumulation of non-infected serum in the middle ear, which is secondary to eustachian tube occlusion and usually the result of swelling and infection of the adenoids, tonsils, or pharyngeal lymphoid tissue. It may be the result of tubal obstruction from nasopharyngeal tumors and can be caused by the patient's habit of sucking air into the nasopharynx through the nose. Allergy as a cause of eustachian tube occlusion has been overemphasized. Most deafness in adults begins with repeated attacks of middle ear catarrh during infancy and early childhood.

Patients with acute secretory catarrh usually complain of poor hearing, a feeling of fullness in the ears, and a sensation of bubbles or movement of fluid when moving the head or blowing the nose. They will notice improvement in hearing when the head is turned to the side or forward, and decrease in hearing when the head is in normal position. The

drum membrane is translucent, a fluid level or bubbles of air may be seen behind it, or bubbles of air may be seen after the patient blows his nose, or after eustachian tube inflation. Paracentesis of the drum membrane reveals a straw-colored exudate and sometimes a stringy or viscid transudate, resembling castor oil or honey, which must be aspirated to be removed.

The condition usually subsides after a week or two, rarely becoming secondarily infected. Many patients suffer a recurrence every time they have an upper respiratory infection. Sooner or later, after such repeated attacks, the mucous membrane of the middle ear thickens, scar tissue forms, the drum membrane atrophies and retracts, and the patient's hearing becomes more or less permanently impaired.

Early paracentesis of the drum is indicated whether the exudate is serous or purulent. Inflation of the eustachian tube will give temporary relief but will not remove the serum from the middle ear. Antibiotics can prevent a secondary infection from the nasopharynx, but they cannot remove the serous accumulation or relieve the blocked eustachian tube. Enlarged adenoids and tonsils should be removed, and nasal obstruction and sinus disease should be adequately treated. Enlargement of the lymphoid follicles in the eustachian tube is an important factor in its occlusion. Treatment with x-ray or radium, after the acute attack has subsided, will reduce the size of these follicles. X-ray or radium will also reduce any associated hypertrophy of the pharyngeal lymphoid follicles and eliminate any crypts which may harbor infection.

Acute Sinusitis

Antibiotics will not resolve sinus infections, acute, subacute, or chronic, if drainage from the sinus cavities is inadequate. Surgical removal of barriers to drainage is often necessary. Chronic nasal sinus disease can be prevented by proper treatment during the acute and subacute stages. This is especially true of acute infections of the frontal and ethmoid sinuses. Although antibiotics are indicated, they will not prevent chronicity and complications when drainage is inadequate. An acute frontal sinus infection, which does not resolve shortly under antibiotics, intranasal shrinkage, and suction, is best drained by external trephining, since intranasal surgery is contraindicated in the acute stage. During the subacute stage intranasal surgery can be accomplished safely.

Allergy

Sinus disease may be allergic or infectious, or both. In the former the discharge is watery or mucoid; in the latter, purulent or mucopurulent. The finding of an abnormal number of eosinophils in the nasal discharge, the history of attacks following exposure to known allergens, and rapid response to antihistamines are characteristic of the allergic type. When one follows the other, or when they are combined, as is often seen in the chronic state, there is no way of distinguishing between them. The cellular reactions to allergens and to infectious agents are similiar. Their treatment is difficult because many of the changes in the nasal tissues are irreversible. Chronic thickening and swelling of the nasal mucosa which appear as hyperplastic tissue or polyposis are typical of allergy, although an infectious process may produce a similar picture. It is believed that almost all chronic sinus conditions have allergic factors, but what these factors are often escapes determination.

There is much confusion and misunderstanding regarding the value of skin tests. They are helpful when the allergic condition is due to inhalants, like pollens, fungi, house dust, feathers, or orris root, but in most cases of food allergy they are of no value. When the offending allergen cannot be found by skin testing, or by history, or by elimination diets, therapy must be empiric. Adrenalin, ephedrine, and similar acting compounds, antihistaminics, calcium, iodine, thyroid and pituitary extract, or a combination of these, with or without some sedative, can be tried. Recently ACTH and cortisone have been used with promising results. Dust injections, when the history points to contact from inhalants and the skin tests are inconclusive, may be worth a trial. Locally, alteration of the nasal mucous membrane is accomplished by chemical cauterization, sclerosing injections, or by electrocautery and radium application. These give relief by decreasing the swelling and reducing the permeability of the nasal mucous membrane to airborne allergens. However, chronic allergic conditions, with or without a suppuration, will not disappear under any such treatment when the changes have become irreversible. Here attention is directed to the removal of obstructions to breathing and promotion of adequate sinus drainage, and to continued search for and neutralization of the offending allergens.

Chronic Sinusitis

The patient with chronic infection of the sinuses usually complains of post-nasal discharge, or of a continual, purulent, nasal secretion, which can be seen in the nasal chambers. The diagnosis is made by x-ray and by sinus lavage when the physical signs are not characteristic. Not infrequently, washing the antrum will terminate a subacute or early chronic infection of the nose. Many chronic nasal infections are due to antrum infections, which will subside when adequate drainage is provided through an antrum window. Removal of the entire infected mucosa of the antrum by the Caldwell–Luc operation may be necessary to effect a cure. After complete removal, the antrum lining is restored in about a year.

The ethmoids, frontal sinuses, and the sphenoid sinuses present more difficult surgical problems because of their anatomical configuration and relationship, but it is surprising how much recuperative power an infected sinus mucosa possesses when one allows natural healing by promoting drainage.

Acute Laryngotracheobronchitis

Acute laryngotracheobronchitis is an acute, descending inflammation of the mucous membrane of the lower respiratory tract, extending from the larynx to the smaller bronchioles. It is characterized first by congestion, edema and the exudation of thick, tenacious secretion, followed by ulceration and crusting in the more severe cases. The pathologic picture is primarily one of toxemia, plus respiratory obstruction. Acute laryngotracheobronchitis occurs most frequently in young children during the seasonal respiratory epidemics. Diphtheria and acute infectious edema of the larynx should be ruled out by culture and direct laryngoscopy.

Medical treatment alone is effective in most cases. If it fails to relieve the obstruction, mechanical aspiration and bronchoscopic removal of the crusts, and tracheotomy may be necessary. In an acute emergency the Mosher life saver tube may be used preparatory to tracheotomy. Tracheotomy should be performed when signs of severe obstruction occur. These signs are as follows: change in the character of the stridor, restlessness, deep retraction of the intercostal spaces, pallor cyanosis, anxiety, and absent breath sounds. Signs of exhaustion, such as listlessness, high fever, and a weak, fast pulse, also call for prompt tracheotomy. Prolonged bronchial obstruction must be avoided, as it may lead to irreversible changes in the respiratory and cardiovascular systems. The tracheotomized child needs constant supervision. Postural drainage, frequent aspiration, and irrigation of the trachea and bronchi are necessary. The inhalation of penicillin and streptomycin through a nebulizer may be of distinct advantage after tracheotomy.

Hoarseness

Hoarseness may be caused by inflammation or growth within the larynx and is important as an early sign of cancer. Examination of the larynx by mirror or by direct laryngoscopy should not be delayed. A biopsy should be made of all suspicious lesions. Cancer of the larynx usually begins on one vocal cord, and can be completely removed by laryngofissure with the sacrifice of only one vocal cord. The removal of only one vocal cord or one-half of the larynx will still permit useful speech. Lasting cure is the usual result upon complete removal in early lesions, since cancer of the vocal cord is slow growing and metastases do not occur until late. When the lesion has spread over the commissure to involve the other cord or the lesion has extended throughout the entire cord and subglottically, total laryngectomy is usually indicated to save the patient's life. A cure can still be expected if the lesion is confined within the larynx proper. However, a laryngectomy results in loss of the voice and the patient must be taught to speak by artificial means. When a laryngeal carcinoma has spread to the extrinsic regions of the larynx, metastases to the cervical lymph glands are usually present, and a cure by surgery or radium cannot be expected. Combined laryngectomy and neck resections materially improve the prognosis in these cases.

Tonsils and Adenoids

Tonsils and adenoids are frequently removed without sufficient reason. These structures are not useless and should not be considered "better out than in" in questionable cases, or removed as a possible prophylactic measure for some future condition. The tonsils and adenoids function as part of the defense mechanism of the body. The early attacks of tonsillitis in childhood are important in the development of the immunologic processes of the body. Enlarged tonsils are not necessarily infected, especially in the child, but small tonsils in the adult may be badly infected. The small, flat tonsil from which milky purulent material can be expressed is often the septic focus which adversely affects the general health of the patient and should be removed. Adenoids should be removed if they cause obstruction to breathing, or when they are the cause of middle ear suppuration or repeated attacks of secretory middle ear catarrh. Tonsil remnants after tonsillectomy indicate an inadequate operation and should be surgically removed.

INSTITUTE ON THE SLOW LEARNER SCHEDULED FOR APRIL 26

The second annual statewide Institute on the Slow Learner will be held at the University of Wisconsin Memorial Union, Saturday, April 26. Its purpose is to increase public understanding of Wisconsin's 35,000 mentally retarded citizens and to present various facets of current care, training and education which are being provided them, by public and private services, in their homes, in school, on the job, in their community as well as in institutions.

The state's top authorities in this field will participate. All meetings are open to the public. They are variously geared to the interests of doctors, nurses, institutional staff, physiotherapists, teachers, physiologists, social workers, clergy, parents, and interested citizens.

Among the sponsors of the Institute are six state agencies, eight voluntary organizations and the three largest parent groups in the state. Further information may be obtained by writing to Room 206, University Extension Building, University of Wisconsin, Madison 6, Wis.

Medical Problems in Atomic Exposure

By GEORGE M. LYON, M. D.*
Washington, D. C.

THE injurious effects observed in individuals exposed to an atomic explosion may be divided into three categories, (a) mechanical injuries, (b) thermal burns, and (c) radiation effects. These effects may be observed singly, or in any variety of combinations.

In Japan it was impossible to determine with absolute accuracy the relative importance of the various causative factors because many individuals injured by the blast were also burned, and undoubtedly many who died from either of these causes might ultimately have died of radiation sickness. There is good reason to believe, however, that at Hiroshima and Nagasaki, not more than 15 per cent of the deaths were due primarily to nuclear radiation effects.

In the case of a high air burst, for example at an altitude of approximately 2,000 feet and above, most of the casualties would be due to thermal burns or to mechanical injuries caused directly or indirectly by the blast. A small proportion would be due primarily to the initial nuclear radiations that are emitted at the time of, or during the first minute after, the explosion. The effects of residual radioactivity under these circumstances would be negligible.

In the case of an atomic explosion at a low altitude, or at ground level, there would be fewer casualties from blast effects and thermal burns. Depending on a variety of factors the number of casualties due to radiation effects might, or might not, be as great. A small area would probably be highly contaminated with radioactive material, but, if proper precautions were taken, the number of casualties due to residual radioactivity should be a very small fraction of the total.

After a shallow underwater or underground burst, the number of casualties resulting from blast and thermal effects would be greatly diminished. It is likely that the same would be true of casualties resulting from the initial nuclear radiations emitted at the time of the explosion. Some casualties might, however, result from the exposure of individuals to the residual radioactivity arising from the atomic explosion. This residual radioactivity would be due mainly to radioactive fission products, and to a lesser extent to bomb material which had escaped fission and to the induced radioactivity resulting from neutron bombardment of certain elements. The employment of well planned and executed radiologic safety measures subsequent to an atomic attack would go far to reduce the number of serious casualties which might result from this form of residual radiation hazard.

Presented before the One Hundred and Tenth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1951.

* Special Assistant for Atomic Medicine, Office of the Chief Medical Director, U. S. Veterans Administration, Washington, D. C.

Mechanical Injuries

The blast effect may cause mechanical injuries directly or indirectly.

Mechanical injuries due to the direct effect of the positive pressure, or "overpressure,"** of the shock wave can cause injury to the lungs, stomach, and other air-containing viscera. Such injuries were observed not infrequently in the large scale air raids of World War II, although they were not observed as a significant cause of death at Hiroshima or Nagasaki. This may have been due to the fact that most of those individuals near enough to suffer such injuries were either burned or crushed to death. It was, however, most likely due to the fact that the peak pressure of the shock wave was so attenuated by the time it reached ground level that it was, for the most part, incapable of producing direct blast injuries in human beings. A pressure of 35 pounds per square inch or more is required to produce direct harm to a human being, while only 2 to 15 pounds per square inch overpressure is all that is required to damage the majority of man-made structures.

Mechanical injuries due to the indirect or secondary effects of the blast were, in the Japanese bombings, more important than the primary blast injuries. Persons were crushed or buried under collapsing buildings, injured by flying objects, and thrown against fixed structures. Glass fragments presented an important problem.

The injuries resulting indirectly from the blast effects varied from complete crushing, internal hemorrhage, severe fractures, and serious lacerations with hemorrhage, to minor scratches, bruises, and contusions. Some individuals were thrown into water and drowned. Fires resulting from blast damage to buildings contributed to the number of thermal burns. Shock was a frequent and serious complication of mechanical injuries.

The number, incidence, and distribution of blast casualties in the Japanese bombings were closely related to the height of the burst, the type of building construction, and the distance from the center of the bombed area. As a matter of fact, there was a close relationship between the range and degree of physical destruction to buildings and the incidence and severity of casualties produced, regardless of the causative factors involved.

** Pressure in excess of atmospheric pressure.

The indirect blast injuries due to an atomic explosion would be similar to those caused by conventional bombs. The important difference would be the much greater number and variety of such injuries produced in a very short period of time in atomic attack.

The number of deaths due to mechanical injuries would be very high during the first 24 hours following an atomic attack. This is probably one reason that more emphasis was not paid to this form of casualty in the early reports on the Japanese bombings.

Doctor Tsuzuki has presented some interesting data in a report from the Medical Section of the Special Committee for the Investigation of the Effects of the Atomic Bomb of the National Research Council in Japan.

In one study the cause of death was analyzed in 490 cases. Of these 26.2 per cent died on the first day of unknown causes, while 45.5 per cent died of mechanical injuries, 16.3 per cent of burns, and 12.0 per cent of radiation sickness. When they assumed that the individuals dying on the first day died of mechanical causes, then this brought the deaths from mechanical injuries up to 70 per cent. The statement is made in the report, "The problem of mechanical deaths, which has been neglectfully dealt with in the past, has become a most important one now."

Among 898 survivors, 35.3 per cent had thermal burns, 60.3 per cent mechanical injuries, and 28.6 per cent radiation effects. The total exceeds 100 per cent because some casualties suffered from more than one form of atomic bomb effects.

In a study of 5,120 survivors at Hiroshima in October and November 1945, 3,942 had received some kind of injury (mechanical, thermal, or radiation) while the remainder escaped any such effects. Of those affected, 2,379 had mechanical injuries, 1,881 had thermal burns, and 909 had radiation effects. Of those receiving mechanical injuries, 80 per cent were indoors at the time of the explosion, and two-thirds of these were in wooden buildings. Of those receiving thermal burns, only 19 per cent were indoors. Of those suffering from radiation effects, there were slightly more indoors than outdoors at the time of the explosion, and of those indoors, four-fifths of them were in wooden houses.

In my opinion, a very significant fact to be gained from these observations is that modern brick and concrete buildings probably offer considerably more protection than is generally recognized, and that wooden buildings of flimsy construction offer relatively little protection, except perhaps against flash burns.

It is likely that mechanical injuries can be expected to account for at least two-thirds of all deaths, and that even among those individuals surviving the first day, the number of casualties suffering from mechanical injuries will outnumber somewhat those suffering from thermal burns.

The treatment of mechanical injuries in atomic attack would pose a serious problem because of the great numbers of casualties involved, and because of the chaotic conditions existing at the time. Many improvisations would be required, and the aim would be to treat these casualties as nearly like those of any civilian or military disaster as possible. The variety of injuries which might be encountered would be so great that it would not be practicable to discuss their treatment in this paper in more than very general terms. These casualties should, however, receive the best possible care which can be provided under the conditions existing at the time. The principles of treatment to be observed would be those already well known to the medical profession. The prevention and management of shock and protection of the casualty from unnecessary handling would be very important.

Thermal Burns

At Hiroshima and Nagasaki two general types of burns were observed. These were (a) fire or flame burns and (b) flash burns due to thermal radiation. The fire and flame burns were similar to those encountered in large scale air raids in World War II with conventional high explosive or incendiary bombs.

The flash burns were of particular importance because of their high incidence and because they were in some respects different from ordinary high explosive burns. In the main, they were due to infra-red radiations. The ultraviolet radiations which are so important in causing ordinary sunburn were not of importance in causing flash burns. These thermal radiations travel in a straight line. As a consequence it was the unprotected areas of the body facing the center of the explosion which were affected. The so-called "profile burn" was a common observation. Clothing, unless very thin, usually afforded some degree of protection. When flash burns did occur through clothing, it usually involved those regions of the body where the clothes were tightly drawn over the skin, such as at the shoulders or elbows. White or light colored clothing afforded relatively more protection than dark clothing.

It is characteristic of such flash burns that a very high surface temperature is produced in a very short interval of time, and that within the depths to which the thermal radiations penetrate, the tissues appear to be completely destroyed. In some instances actual charring of the skin was observed. The flash burns varied from mild first degree burns to severe third degree burns, the latter being relatively uncommon. The incidence of flash burns observed and the severity of the initial burn-wound incurred was inversely related to the distance from the explosion. As might be expected, however, the area of skin surface affected was an additional and very important factor in determining the severity of the illness due to flash burn.

In Japan, erythema of those parts of the skin exposed to thermal radiation appeared almost immediately and was followed by progressive darkening and blistering within a few hours. First degree

burns that were not irritated healed promptly. Second degree burns were frequently irritated or became infected and healing was delayed accordingly. Excessive scar formation was frequently observed and was undoubtedly influenced by secondary infection and inadequacy of wound hygiene. Rarely if ever were these overgrowths of scar tissue or keloids due to nuclear radiation as many people have surmised. Third degree burns, while not so common among survivors as the less severe burns, posed a serious problem and contributed significantly to the total number of deaths. Shock was also a serious problem.

The margins of healed flash burns were usually sharply defined. The edge of the scar showed a denser pigmentation that tended to fade to a lighter color toward the center. A narrow zone with loss of pigment was often observed in the skin adjacent to the margin of the healed burn. There was no connection between these unusual pigmentation effects and nuclear radiation as some have surmised.

Hair exposed to thermal radiation was sometimes burned off or singed. Sweat glands and hair follicles were at times injured or destroyed in this manner. That such effects were due in many instances to thermal radiation rather than to nuclear radiation is shown by the fact that the area of the scalp damaged was restricted to that area not protected by a cap, or shaded. The cap would not protect against the gamma rays of the atomic explosion. For practical purposes of diagnosis and treatment it is not necessary to differentiate between flame burns and flash burns due to thermal radiation.

The general treatment of the burn patient is of great importance. The need for whole blood and blood derivatives in severe burns is generally recognized. The need for protective and supportive care is also well recognized. How to provide all of these at the time, and in the manner desired, would be a difficult problem in event of an atomic attack.

With regard to the external treatment of a burn wound, there is a variety of methods currently in use, none probably strikingly superior to the others. Each physician should be free to use the method of his choice, providing the supplies and personnel required are available at the time. Because of the difficulty of meeting these latter requirements, it is imperative that the variety of emergency treatments be reduced to a minimum, preferably to one type, in making civil defense preparations.

The Federal Civil Defense Administration has outlined the criteria for a satisfactory local burn treatment for civil defense purposes.[1] It has also described a type of treatment that meets these criteria better than any other existing method.[1] It is based on the principle of a dry dressing, which provides a protective covering, relieves pain, and bars further introduction of pathogenic organisms. Its absorbability prevents rapid total saturation with exudate which would require undesirable frequent changes of dressings. It is a cellulose pad one inch or more in thickness, faced and backed with gauze. It is similar to a sanitary napkin. The gauze facing is very fine in order to minimize sticking to the burned surface. The back is of coarser gauze. It is proposed that two sizes be available, (a) 12 by 24 inches for application to extremities, and smaller burned areas, and (b) 24 by 36 inches for larger burned areas of the trunk. The pad is held in place by a tensile yarn roller bandage applied firmly and evenly but with only gentle pressure. Three and six inch widths of roller bandage are proposed as most desirable.

The application of these dressings in emergency conditions would be carried out by civil defense first-aid workers. They would also remove from the burned area of the body, large and easily separated particles of clothing, dirt, debris, and skin prior to applying the dressing. Later a physician might remove the dressing to inspect and clean the area. At this time a new cellulose dressing could be applied or another method of dressing employed if this were desired and the supplies required were available.

This in brief outlines the plan of emergency treatment proposed by the Federal Civil Defense Administration. In the event such supplies were not available, it would be desirable to improvise procedures as nearly like those proposed as possible.

Radiation Effects

A unique feature of the atomic bombings in Japan was the occurrence of a large number of illnesses due to exposure to nuclear radiation emitted at the moment of the explosion, or within a minute thereafter. The offending nuclear radiations were gamma rays, or a combination of gamma rays and neutrons. This was the first time that it was possible to observe large numbers of patients whose entire bodies had been exposed to radiations of this character. The resulting illness has been referred to as "radiation sickness."

Because there was no significant residual radioactive contamination, the superficial "radiation injuries" which characteristically are not accompanied by any general systemic effects and which may result from contact, or near contact, with radioactive materials were not observed. In this form of radiation injury the beta-emitting radioisotopes would usually be the chief offenders, and only to a lesser extent the gamma-emitters and the alpha-emitters.

When radioactive materials gain access into the body and are retained within the body for a period of time, "radioactive poisoning" may result. This may occur as a result of ingestion or inhalation of radioactive materials. The most serious offenders in this respect are likely to be beta-emitting and alpha-emitting substances and only to a lesser extent gamma-emitters. No instances of radioactive poisoning were observed in Hiroshima or Nagasaki. Because there was no residual radioactive contamination, this would have been anticipated.

Radiation Sickness

As observed in Japan, the patients suffering from radiation sickness could be placed in three different groups depending upon the characteristics of the clinical findings observed and the course of the illness. There was undoubtedly a close relationship between the severity of the exposure and the gravity of the illness.

In the very severe clinical form, malaise, nausea, and vomiting began one or two hours after exposure and persisted for several days. Prostration was present early and continued. Leukopenia and particularly a lymphopenia was observed early, and it tended to be persistent and severe. Within a few days diarrhea occurred and was persistent. Fever was observed to occur within a few days, and generally the earlier its appearance the more grave the illness. Death some time before the end of the second week was the usual outcome. It occurred in some instances as early as a few hours after exposure. When death occurred late in the second week, epilation and purpura were sometimes observed. The hemorrhagic manifestations were probably not responsible for death in these very severe, rapidly fatal cases.

In the severe clinical form nausea and vomiting occurred on the first day but usually did not persist for more than 24 hours. There was a lymphopenia after the first day. Then there was a latent period which might be as short as 4 days or as long as 20, during which there was a steadily increasing malaise, the patient tired easily, and the lymphocyte count was depressed. Once the latent period was over (4 to 20 days) an acute exacerbation of symptoms occurred, and the patient became seriously ill. Any or all of the following symptoms of radiation sickness might be encountered: (a) epilation, particularly of the scalp, (b) purpura, and other hemorrhagic manifestations such as melena and bleeding from the nose and uterus, (c) edema, infection and ulceration of the oropharynx, (d) fever, (e) diarrhea, (f) severe leukopenia, (g) secondary infections, (h) breaking down of healing wounds or delayed healing, and (i) general sepsis. The severe hemorrhagic tendency was characteristic. When death occurred, it was usually due to loss of blood, to general sepsis, or to hemorrhages into vital structures. Hemorrhages have been observed in all tissues of the body, including the brain and heart muscle. Death may occur anytime before the sixth week. The blood findings were most marked during the third to fifth weeks. These included severe leukopenia, severe anemia, thrombocytopenia, and prolonged bleeding and clotting time. Increased permeability of the capillaries was also observed, and may have been related in part to direct effects in the capillary bed and in part due to injury to the reticulo-endothelial system. When recovery took place there was a slow return to normal with the anemia and general weakness often continuing for some time. It has been estimated that in Japan the mortality rate among casualties suffering from this form of radiation sickness was between 25 and 50 per cent. Certainly, good medical care could help to reduce the mortality rate in such cases, because little could be done for these patients in Japan.

In the mild to moderately severe clinical form, vomiting may have occurred some time the first day, and during the ensuing two weeks there were usually no symptoms, although if a blood count had been taken, a moderate lymphopenia would have been observed. After the second week one or several, rarely all, of the following symptoms were observed: (a) epilation of the scalp, (b) malaise in varying degrees but probably persistent, (c) sore throat, (d) petechiae of skin and mucus membranes, (e) diarrhea, perhaps bloody, (f) loss of appetite, and (g) loss of weight. The "latent period" was longer than in the more severe forms. The blood changes were less marked and their appearance occurred somewhat later in the course of the disease than in the more severe forms. Deaths occurred mainly after the sixth week, and they were usually due to some complication such as tuberculosis, bronchiectasis, chronic abscesses or septicemia, anemia, or malnutrition. Less than 10 per cent of the patients in this group died.

The clinical diagnosis of severe radiation sickness would probably not be difficult in time of an atomic attack. It would be more difficult to diagnose the milder cases whether they are observed as isolated instances or in atomic attack.

Epilation and purpura are considered as specific evidences of radiation sickness. Suggestive symptoms with a high degree of correlation are vomiting on the first day of the exposure, oropharyngeal lesions which occur during the first six or seven weeks, and hemorrhagic manifestations other than purpura. There was poor correlation with respect to loss of appetite, malaise, diarrhea, bloody diarrhea, and fever.

Epilation was usually confined to the scalp. It appeared as early as two weeks after exposure, but was most commonly observed to appear during the fourth week. In survivors the hair had grown in again by the fifth month.

Purpura of the skin was usually not observed before the third week, most usually not until the fourth week. Patients with both epilation and purpura usually had the lowest leukocyte counts.

The oropharyngeal lesions were important. They seldom appeared before the third week, most usually during the fourth week. The mucous membranes were inflamed and dusky in appearance. The gums were swollen, sore, and inflamed. There was frequent ulceration. The lesions frequently resembled those seen in an agranulocytic angina.

The hemorrhagic manifestations were of almost every conceivable variety. Most patients with cutaneous purpura had other evidences of the hemorrhagic tendency. In general, the earlier the symptoms the more severe the radiation sickness. No single laboratory procedure is by itself diagnostic

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of radiation effects. Severe radiation injury results in a marked leukopenia, thrombocytopenia, and anemia.

Leukocyte counts of less than 1,000 per cubic millimeter were observed during the first week; recovery was rare in individuals with counts as low as 500.

Lymphocyte counts are of greater diagnostic value than leukocyte counts during the first few days after exposure because they start to decrease immediately after exposure. A lymphocyte count of 800 per cubic millimeter within 48 hours after exposure may be presumptive evidence of severe radiation effects, and a count of 1,500 per cubic millimeter after 48 hours suggests that clinically significant radiation injury is unlikely. The neutrophilic granulocytes and thrombocytes decrease less rapidly than the lymphocytes.

The anemia develops somewhat more slowly, sometimes not being evident before the second or third weeks. The lowest counts are observed usually in the fourth and fifth weeks after exposure. The return to normal may be similarly retarded and slow.

Capillary fragility, prolonged bleeding time, and prolonged clotting time are characteristic of the hemorrhagic state that begins usually between the second and fourth weeks.

The diagnosis of radiation sickness, and the evaluation of its severity, is primarily a clinical problem and in most instances can be satisfactorily made solely on the basis of the history and the physical examination. Laboratory studies, when they can be made, may provide additional assistance of particular value in estimating the severity of the illness.

Treatment in Radiation Sickness

There are at present no specific therapeutic agents for the treatment of patients suffering from radiation sickness. Treatment is symptomatic and supportive. In the very severe group of cases, little can be done to change the eventual outcome. In the severe group of cases and in the mild to moderately severe group of cases, much can be accomplished by means of good medical and nursing care and by appropriate symptomatic and supportive treatment.

In the very severe cases the treatment indicated would include rest and freedom from strenuous activity from the onset of symptoms, which is likely to be within the first day or so after the exposure. Attention should be paid, where possible to do so, to fluid replacement, restoration of electrolyte balance, and sedation as needed. Antibiotics and whole blood transfusions will not influence the situation very much, but should not be withheld when clear-cut indications for their employment exist in an individual case.

In the severe cases, little medical and nursing care may be required during the first few days after the exposure. In fact the true state of affairs may not even be suspected during this period, the first strongly suggestive indications being the appearance of the active symptoms at, or near, the end of the so-called latent period. Of course the existence of a lymphopenia, which under the distressing conditions of large scale disaster would be difficult to detect in most instances, could be taken as strongly suggestive evidence and should be heeded. In such cases strenuous physical activities should be avoided as much as possible. With the appearance of the characteristic symptoms, treatment should be aimed, as indicated, at the maintenance of nutrition, the restoration of water and electrolyte balance, the prevention and control of infection, and treatment for hemorrhage and anemia. The illness in the early stages resembles agranulocytic angina, and later the hemorrhagic manifestation, the tendency to secondary infection, and malnutrition become prominent. If the patient can be tided over that period during which there is a more or less complete depression of the blood forming tissues (and this period may be as long as two to five weeks) in most instances these tissues recover their normal function, and the body will regain its normal ability to combat infection, and the patient will recover. From the very beginning, treatment should be directed at minimizing the effects of the tendency to hemorrhage and the inability of the body to combat infection. The value of antibiotics and whole blood transfusions was amply demonstrated in Japan. When severe symptoms appear, antibiotics should be administered, if possible both orally and parenterally. Sulfonamides may be employed if antibiotics are not available. Whole blood transfusions are the only effective treatment for hemorrhage and anemia. Where possible the blood hemoglobin should be maintained at a level of 10 Gm. or more per hundred cubic centimeters.

In mild or moderately severe cases the same general principles of treatment as have been described for the more severe cases should apply except that they should be modified to suit the clinical indications encountered in the individual case. The need for antibiotics and for whole blood transfusions would not be nearly as imperative as in the more severe cases. Some individuals with the more severe symptoms may, however, require these forms of treatment. Because the severity of illness will range from mild to moderately severe, the requirements in individual cases will vary considerably.

Late effects have been observed in the Japanese survivors only to a limited extent. Cataracts due to exposure to the initial nuclear radiations have been observed in survivors who were within a range of about 1,000 meters of the center of the explosion area at the time of the explosion. The incidence of leukemia has been somewhat higher among the survivors who were exposed to the initial radiations than among the Japanese population as a whole. Survivors temporarily sterile have regained their fertility, and no unusual incidence of abnormal offspring has been observed.

Combinations of Atomic Bomb Effects

Previously in this paper, for the sake of simplicity, the various forms of atomic bomb effects on people have been treated as if they occurred separately. In many instances this was not the case. Some casualties suffered from all three forms of atomic bomb effects. Others suffered from both mechanical injuries and thermal burns, or from mechanical injuries and radiation effects, or from thermal burns and radiation effects. It was frequently impossible to tell just which form of atomic bomb effect was the more important clinically. While it is not known to what extent one form of injury aggravated the other, in many instances it must have been of considerable importance. It is known that when radiation sickness occurred in a casualty suffering from a wound caused by mechanical means, or from a thermal burn, that it was often a matter of great clinical importance. In such instances there was, besides the general deleterious effect, usually a tendency for the healing wound, or burn, to break down and healing and repair were much slower than would have occurred otherwise. Special care had to be given to wounds and to burns in those casualties who were suffering from radiation effects. Added protection and special precautions intended to prevent and control infection were usually required. The use of antibiotics and of whole blood transfusions was particularly indicated in such instances.

Medical Research

Although a great deal is already known with respect to many aspects of atomic bomb effects on people, much remains yet to be learned. The Atomic Energy Commission and the National Academy of Sciences are together conducting a very important study of the survivors in Japan. The Atomic Energy Commission, as well as the Armed Services, is conducting, or supporting, research in many aspects of these varied problems, often in connection with civilian universities and medical schools. Important biologic studies were made in the recent atomic bomb tests at Eniwetok.

Medical Preparedness

There is probably no more pressing or more perplexing problem facing the medical profession today than how to develop and maintain a state of medical preparedness for atomic attack on our civilian communities. Unfortunately this requires something more than the knowledge of how to diagnose radiation sickness and treat patients suffering from atomic bomb effects. Important as this knowledge is it can not be applied as it should be unless a reasonably effective scheme of medical participation within civil defense activities can be developed and maintained in most of our communities. Many, but not all, of the difficulties which beset the attainment of this goal lie beyond the direct control of the medical profession. The problem of civil defense organization, planning, and operation are formidable, as indeed also are those of medical and surgical supplies for civil defense purposes.

The Council of National Emergency Medical Services of the American Medical Association has done much to bring these matters to the attention of our profession and in most communities medical planning has been ahead of other civil defense planning within the community. We must not let our interest in these matters lag. By the very nature of our professional privileges and responsibilities we are committed to a serious obligation in an area of human relations where others are not qualified or prepared to serve and that is the preparing for, and the providing of, medical care for those of our fellow citizens who may someday be the casualties of an atomic attack on our country.

REFERENCES

1. Health Services and Special Weapons Defense, prepared for the Executive Office of the President by the Federal Civil Defense Administration, Washington, D. C., Government Printing Office, 1950, paragraphs 7.32 and 7.33.

SUMMER CAMP SCHEDULED FOR DIABETIC CHILDREN

A summer camp for diabetic children will be opened for the fourth season under the auspices of The Chicago Diabetes Association, Inc. from July 1, 1952 to July 22, 1952 at Holiday Home, Lake Geneva, Wisconsin.

In addition to the regular personnel of the camp, there will be a staff of dietitians and resident physicians, trained in the care of diabetic children, furnished by The Chicago Diabetes Association.

Boys and girls, ages eight to fourteen years inclusive, will be accepted at a fee of $120.00 (which covers the three week camping period and transportation from Chicago). Fee reductions may be arranged when considered necessary.

Physicians are requested to notify parents of diabetic children and to supply the names of children who would like to attend camp. Applications may be obtained from, and inquiries should be addressed to: Service Unit, Chicago Diabetes Association, 110 South Dearborn Street, Chicago 3, Illinois.

Limited capacity requires prompt application.

Proceedings of the Milwaukee Academy of Medicine, November 20, 1951

The Most Detectable Internal Cancer

By RICHARD OVERHOLT, M. D.
Boston, Mass.

GREAT promise in the treatment of bronchogenic cancer is developing mainly because of the ease with which this malignancy may be recognized. No other internal cancer lends itself to easier roentgenographic visualization. The normal air of the lung supplies an excellent natural contrast for identification of changes produced by neoplastic growth. According to some radiologists, lesions as small as 3 mm. might be recognized. Mass roentgenographic surveys have uncovered many asymptomatic bronchogenic carcinomas, particularly as a by-product of screening programs for tuberculosis. The discovery of silent pulmonary lesions in this manner has awakened physicians to the tremendous possibilities of early diagnosis.

In patients with such lesions, bronchoscopic examination often is negative. Even in symptom-producing primary cancer of the lung, bronchoscopic examination made the diagnosis in less than 40 per cent of the patients.

The study of sputum for cancer cells usually gives positive results in about 50 per cent of the patients with symptoms. Among the patients found to have pulmonary lesions during a recent survey conducted by us, only 25 per cent had diagnostic changes in the sputum.

Careful follow-up study of patients with silent lesions is of the greatest importance. They may remain silent for years, but most will produce symptoms sooner or later. Because of the limitations of bronchoscopic examination and histologic studies of the sputum as diagnostic procedures, many of these patients will need surgical exploration of the thorax. The trend now is to operate earlier in doubtful cases. The importance of early intervention in pulmonary lesions is emphasized by our experience as well as that of others: 50 per cent or more of patients operated on are found to have malignant conditions. In the Boston survey where 398 patients were found with suspicious lesions, 76 were ultimately diagnosed as primary cancer of the lung.

Since surgical exploration for lung cancer carries a risk as low as that of abdominal exploration, time need not be wasted with ineffectual attempts to rule out other conditions. During the asymptomatic phase the tumors are all resectable and the lymph nodes are free of extension in 70 per cent; however, by the time symptoms have appeared only 30 per cent of the tumors are resectable and about 10 per cent are free of lymphatic extension. Lesions other than cancer found on thoracotomy may also be removed with beneficial results to the patient. This is true of benign tumors as well as tuberculomas.

If we are to make progress in the field of pulmonary cancer, we must encourage roentgenographic surveys and plead for rapid follow-up of suspicious lesions. Surgical exploration during the asymptomatic phase of the disease offers the best chance of cure.

SECTIONAL MEETING OF AMERICAN COLLEGE OF SURGEONS TO BE HELD IN MINNEAPOLIS

A three day sectional meeting of the American College of Surgeons will be held at The Radisson Hotel in Minneapolis, Minnesota, on March 24, 25, and 26.

The program will include two days of scientific sessions at The Radisson Hotel and a day of teaching clinics and demonstrations in Minneapolis hospitals. Distinguished speakers will present papers, panels and symposia on current surgical problems, and extensive programs for specialists in ophthalmology and otolaryngology have been prepared for March 25. New surgical motion pictures will be shown, including several which were prepared especially for the Cine Clinics at the 1951 Clinical Congress, and also a stereoscopic colored film on "Radical Resection for Carcinoma of the Stomach."

Incidence and Importance of Lesions Found in Routine Proctosigmoidoscopy

By LYLE W. SWARTZ, M. D.*
Milwaukee

THE data for this paper were obtained from 6,753 consecutive proctosigmoidoscopic examinations made over a five year period. All the patients presented themselves for examination because of rectal complaints. Among these patients 585 (8.6 per cent) were found who had new growths in the lower bowel within reach of the proctoscope. Of these, 368 (5.45 per cent) were benign and 217 (3.21 per cent) were malignant. Only new growths are considered in this paper; pathologic lesions such as ulcerative colitis are excluded.

TABLE I

	Number	Percentage
Consecutive proctoscopic examinations	6,753	100.00
New growths found	585	8.66
Benign	368	5.45
Malignant	217	3.21

The sex distribution of the 6,753 patients was roughly one to one, but, among the 585 patients who had new growths, the men outnumbered the women 441 to 144, or about 3 to 1.

A proctoscopic examination is simple and easy for those adequately trained and can be done in the office. We use a high cleansing enema of one or two quarts of warm tap water. The left lateral Sims position is used because it is easier on the patient, especially an elderly or weakened individual. With a little practice the examiner usually finds this position much easier on himself. Skill in using the Sims position facilitates examining patients in bed. We use a standard Welch–Allyn 25 cm. instrument for routine work. A 30 cm. or 35 cm. scope is used where more range is needed. It is important to have a clean bowel, and to look at and see every portion of it. A small amount of stool or debris may hide a small polyp. X-ray studies with barium enema and barium meal are made on all patients needing further investigation.

It should be stressed that x-ray is not a substitute for a careful and thorough proctoscopic examination. Radiologists and surgeons active in proctologic work know that colon x-ray following a barium enema will not show every defect in the lower bowel. The patients should have the proctoscopic examination *first* because x-rays often do not show even sizeable defects below the brim of the pelvis. This cannot be stressed too emphatically. A negative x-ray film does *not* rule out a growth in the lower six to eight inches of bowel.

Treatment consisted of surgical removal of the entire lesion by one of three ways: (1) spot fulguration, (2) biopsy and loop cautery, or (3) abdominal resection or other surgical procedure depending on the findings. All polypi too small to be removed by loop cautery were spot fulgurated with a coagulating current from a Bovie electrosurgical unit. Larger polypi were completely burned off with electrocautery by a loop snare around the bases or pedicles of the polypi. All specimens were examined microscopically after removal. The bases of the lesions were spot fulgurated. Many pedunculated polypi which appeared benign had malignant changes in the tip, even though there was no evidence of malignancy in the pedicle itself. We feel that all polypi are potentially malignant; thus it is very important to locate and remove these early lesions. Larger new growths were biopsied with a biopsy forceps through the proctoscope and examined under the microscope. If the tumor was small and did not appear to have penetrated the muscular wall of the bowel, it was removed by loop cautery or spot fulguration. It is well known that many malignancies are slow to metastasize and that they can be cured if found early. Larger growths not amenable to fulguration through the proctoscope were immediately referred to surgeons for resection or other operative intra-abdominal work as indicated.

Removal of growths by fulguration should not be attempted by physicians not thoroughly trained and experienced in such work. It is a delicate procedure and serious complications such as perforation of the bowel or serious hemorrhage can occur. However, it is within the province of *every* practicing physician to make routine proctoscopic examinations and find the lesions early when cure is possible.

We use both the Cameron and the Phillips–Drucker types of snares, depending on the nature of the lesion. The left lateral Sims position is preferred. If a lesion on the posterior wall of the rectal pouch is difficult to visualize in this position, the patient can be put in stirrups. No anesthetic is required since fulguration of lesions above the internal sphincter is not painful.

Occasionally the surgeon is unable to find a polyp when he enters the abdomen. The proctologist can be of great help by inserting the proctoscope just before the anesthetic is started and locating the lesion for him. A tenaculum is passed through the proctoscope and fastened to the lesion or to the bowel lumen itself at the level of the lesion. The

* From the Johnson Clinic.

proctoscope is then withdrawn leaving the tenaculum in place. After the surgeon enters the abdomen and has the location marked, the tenaculum is withdrawn. The surgeon can then proceed with the resection, confident he has the lesion in the portion of bowel wall which he removes.

Conclusions

The incidence of polypi and other new growths of the lower bowel is higher than generally supposed; 8.66 per cent of our 6,753 patients showed a new growth of some kind on proctoscopic examination, and 3.21 per cent of the series had a growth proved already malignant by microscopic examination.

A negative x-ray study of the lower bowel does not rule out a lesion in the distal six to eight inches of the lower bowel.

More proctoscopic examinations should be made. The large number of benign and malignant lesions found in routine proctosigmoidoscopic examinations indicates that many new growths are being overlooked by physicians who do not include a proctosigmoidoscopic examination of every patient as a part of their routine work-up.

Careful follow-up examinations at frequent intervals are important in all patients treated for tumors in the rectosigmoid area.

INDUSTRIAL CLINICS SCHEDULED

The Committee on Industrial Health announces three Industrial Health Clinics to be held this spring, with the first meeting on March 13 in Milwaukee as a feature of the Central States Society of Industrial Physicians and Surgeons meeting and the regular monthly meeting of the Medical Society of Milwaukee County. This program, as well as the other two clinics are under the active sponsorship of the Committee on Industrial Health of the State Medical Society, the Industrial Hygiene Unit of the State Board of Health, and the Industrial Nurses Section, of the Wisconsin State Nurses Association.

Details of the Milwaukee program, on March 13, are as follows:

10:00 a. m.: COLUMBIA HOSPITAL: 3321 N. Maryland Ave.

"SALVAGING THE INJURED HAND": Symposium with Wm. Frackleton, M. D., president, American Society for Surgery of the Hand, and Harvey S. Allen, M. D., professor of surgery, Northwestern University School of Medicine

12:30 p. m.: TOUR OF MILLER BREWING COMPANY PLANT: Register at 4000 W. State St. Special features: hazards relating to eye injuries, lacerations, employability of diabetics.

1:30 p. m.: COURTESY LUNCHEON: Miller Brewing Co.

3:00 p. m.: SCIENTIFIC PROGRAM: Elston L. Belknap, M. D., President, Central States Society of Industrial Physicians and Surgeons, moderator

"Greetings from the Miller Brewing Company"

Film: "Your Ear and Noise"

"Medical Aspects of the Industrial Noise Problem": Meyer Fox, M. D., Milwaukee

"Employability of the Older Worker": Leonard J. Goldwater, M. D., professor of industrial hygiene, Columbia University School of Public Health, New York

6:30 p. m.: DINNER: MILWAUKEE ATHLETIC CLUB: 764 N. Broadway

(March Meeting of Medical Society of Milwaukee County)

N. J. Wegmann, M. D., Pres., Medical Society of Milwaukee County, Chairman

"Backache Due to Gynecologic Pathology": Edward M. Dorr, M. D., assistant professor of obstetrics and gynecology, Northwestern University School of Medicine

Symposium on PROBLEMS OF WOMEN IN INDUSTRY

Chairman: Roland Cron, M. D., professor of obstetrics and gynecology, Marquette University School of Medicine

Participants: E. J. Schowalter, M. D., medical director, Western Electric Co., Chicago
Henry Hesseltine, M. D., professor of obstetrics and gynecology, University of Chicago

OTHER CLINICS

In addition to the Milwaukee Clinic similar meetings have been scheduled at Eau Claire, on April 2, and at Kenosha on May 7. In Eau Claire the U. S. Rubber Company plant will be used as the site for the plant tour, and in Kenosha the Nash Motors plant will be visited. Scientific programs are being arranged for each of these conferences.

If you have not received a reservation slip for the clinic you wish to attend, please write the Industrial Health Committee, State Medical Society office, Box 1109, Madison, and more detailed information, and a dinner reservation blank will be sent you.

Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

Urinary Antiseptics

Accumulating evidence indicates that Chloromycetin is more bacteriostatic than Aureomycin against gram-negative bacilli in the urinary tract. It is often effective in both proteus and pyocyaneus cases, and the concomitant employment of Gantrisin sometimes seems to potentiate the action. However, in one recently reported study, 9 of 33 strains of gram-negative organisms from the urine of 24 patients had become less susceptible, and there was associated therapeutic failure in 5 of these 9 instances. It is advisable to hit hard with this drug, if it is to be used at all; such dosage as 3 Gm. within the first one and one-half hours, to be followed by 0.5 Gm. at six hour intervals round the clock.

Experience with Terramycin is still relatively limited, but results have been good in most instances, with poor or equivocal action principally in proteus and pyocyaneus infections.

It seems to me that four things importantly militate against routine employment of Aureomycin, Chloromycetin or Terramycin in run-of-the-mill urinary tract infections: first, the likelihood of causing nausea and vomiting; second, the likelihood of causing proctitis; third, the possibility of establishing resistant strains of the organisms concerned; fourth, the cost of these drugs, which is considerable.

Mandelamine and the sulfonamides are still good urinary antiseptics.

Mandelamine effectively controls about 75 per cent of the common urinary infections in 3 to 14 days, perhaps usually in 6 to 7 days. The sulfonamides will not ordinarily do much better than this, and sensitivity to Mandelamine is not lost as it may be to the sulfonamides and antibiotics. Escherichia coli and Streptococcus fecalis are particularly susceptible to Mandelamine, but Aerobacter aerogenes, Pseudomonas aeruginosa and Proteus vulgaris are often resistant. Unless there is a retention catheter, Mandelamine will cure about a third of the cases of neurogenic bladder infections in 30 to 90 days. It is certainly the safest of all drugs for such prolonged use.

Mandelamine adult dosage is three of the 250 mg. tablets after meals and on retiring, without restrictions regarding food or liquids ingested. Infants may be given 250 mg. twice daily; children over 5 years of age, 250 mg. three times daily. Mandelamine tends to acidify the urine, but ammonium chloride or acid sodium phosphate may be given in 0.5 to 1.0 Gm. dosage four times daily if necessary to keep the urine at or below the point at which nitrazine paper changes color.

Among the sulfonamides, sulfacetimide (Sulamyd) is particularly effective in Esch. coli cases. Its toxicity is low and use of alkali is unnecessary to insure solution in the urine. Adult therapeutic dosage is 1.0 Gm. three or four times daily; for children, 65 mg./kg. The drug is much used in the prophylaxis of cystoscopy infections; 0.5 Gm. (one tablet) four times daily for three days after the instrumentation, or beginning two days before if there is stricture.

Gantrisin controls some infections insusceptible to the other sulfonamides. Proteus vulgaris usually succumbs to it. Adult dosage is 1 Gm. four times daily; for children of 5 years, one-half this amount. Use of alkalis is unnecessary.—HARRY BECKMAN, M. D.

MARQUETTE SCHEDULES POSTGRADUATE COURSES

Marquette University School of Medicine will offer a postgraduate course in gynecology on March 5, 12, and 19. Directed by Dr. Roland S. Cron, clinical professor and director of the department of obstetrics and gynecology, and Dr. F. Jackson Stoddard, assistant clinical professor of obstetrics and gynecology, the course will consist of three full day sessions. The first two days will be devoted to discussions at the Medical School, and the course will conclude with an all day clinical demonstration at the Milwaukee County Dispensary on March 19.

The postgraduate department is also planning a course in neurology to be given April 10, 17, 24, and May 1. Directed by Dr. John L. Garvey, clinical professor and director of the division of neurology and Dr. Francis J. Millen, clinical instructor in neurology, the course will stress fundamental technics in the neurologic examination and the rational selection of laboratory, electric and roentgenologic diagnostic aids. Modern treatment of diseases detectable by these means will be correlated in discussions at the Medical School and during case presentations and rounds at the Veterans Administration Hospital.

As It Looks to Your State Board of Health

(These timely discussions of health problems are prepared by staff members as a special service to Wisconsin's physicians.)

A Pamphlet Can Help

A few carefully selected, attractive pamphlets can be a small but important part of the practicing physician's public relations program—a program that helps the public acquire a sane approach to health problems. This is a tangible evidence of the doctor's interest in preventing disease. As the doctor discusses the importance of immunization with parents, he may offer them the pamphlet, "Immunization," which was recently approved by the Maternal and Child Health Committee of the State Medical Society. Later at home the parents re-read the brief, illustrated text which helps to clinch the points he made.

Every day a Wisconsin woman dies of cancer of the breast. That makes "A Message to Women—Cancer of the Breast" of vital importance to women patients. It reminds them to follow their doctors' instructions for monthly self-examination.

Of special interest to dairy farmers is the leaflet "Brucellosis Can Be Prevented," which was approved by the Committee on Rural Health and Accident Prevention of the State Medical Society.

Our bi-monthly bulletin, "Health," is written and illustrated to interest lay readers. Your copy could be placed in your waiting room and thus made available to a large number of patient-readers.

Among the many pamphlets which the State Board of Health has for distribution without charge, the following are especially suited for distribution by the physician:

"Chicken Pox, Mumps, German Measles"
"A Message to Women—Cancer of the Breast"
"Immunization"
"You and Coronary Heart Disease"
"Brucellosis Can Be Prevented"

Write for a supply for your waiting room.—RALPH KUHLI, *Director, Division of Health Education.*

THE MEDICAL FORUM

MIGRANT WORKERS PRESENT GROWING MEDICAL PROBLEM

WISCONSIN HOSPITALS SHOULD SELECT no Priority 1 physicians as residents during 1952–53, is the advice of the Committee on Military Medical Service of the State Medical Society based on national directives. The Committee met recently in Madison: Top—O. G. Moland, Augusta (L) and F. L. Weston, Madison, chairman; Lower—C. N. Neupert, Madison, (L) and M. J. Musser, Madison. Drs. M. J. Sullivan, Milwaukee, and M. H. Steen, Oshkosh, are also members of the committee.

Madison, Feb. 4—Medical care problems with migrant workers are likely to increase rather than decrease unless solutions are found within the near future, physicians learned recently at a meeting of doctors and representatives of state agencies.

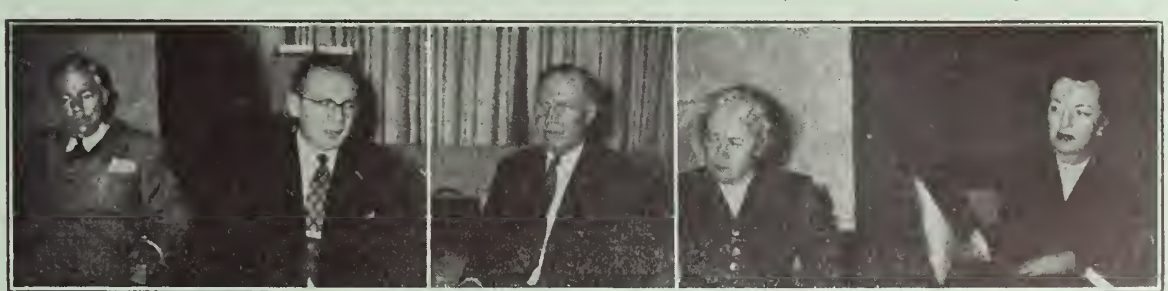
The group met at the State Medical Society headquarters to discuss medical problems of the 6,000 migrant workers who come to Wisconsin each year. At least 4,000 more migrants could be used in the state labor market, according to reports.

The committee recommended that:

1. county medical societies find out from their local relief departments who will assume authority for payment of medical and hospital bills for migrant workers, most of whom are unable to pay the cost of care by themselves.
2. employers be encouraged to hire only such workers as have been screened for diseases. The "tight" labor market makes its unlikely, however, that many employers will follow this suggestion.
3. hospitals set up routine Wassermann and chest x-ray procedures for all migrant workers admitted to hospitals.

Physicians reported problems relating to follow-up care for workers who leave Wisconsin shortly

(Continued on page 192)



MIGRANT WORKERS COMMITTEE met at State Medical Society recently. Among those present were (l. to r.): Harry Nelson, State Industrial Commission; Marvin Verhulst, Wisconsin Canners Association; Herbert Smith, State Employment Service; Miss Maude Swett, Industrial Commission, and Miss Jenny Lind, State Department of Public Welfare.

MEDICAL SOCIETY SCORES "HIT" AT FARM & HOME WEEK

Dr. MacCornack Directs Program and Exhibit

Madison, Feb. 9—More than 5,000 people are estimated to have seen the State Medical Society's exhibit at one of the most successful Annual Farm and Home Week programs in University of Wisconsin history.

Throughout the week of Feb. 4–8, the exhibit was a major attraction in the stock pavilion of the University which served as the focal point of activities.

The exhibit dramatically illustrated the benefits of animal research to both man and animals. An automatic slide projector flashed a series of 30 color pictures on a screen continuously from 8 a.m. to 9 p.m. each day.

Another highlight of the Farm and Home Week session was a half-day program on rural health problems. Both the exhibit and the health program were prepared and presented under the direction of Dr. R. L. MacCornack, Whitehall, for the Council on Medical Service of the State Medical Society. Dr. MacCornack is in charge of rural health activities of the council.

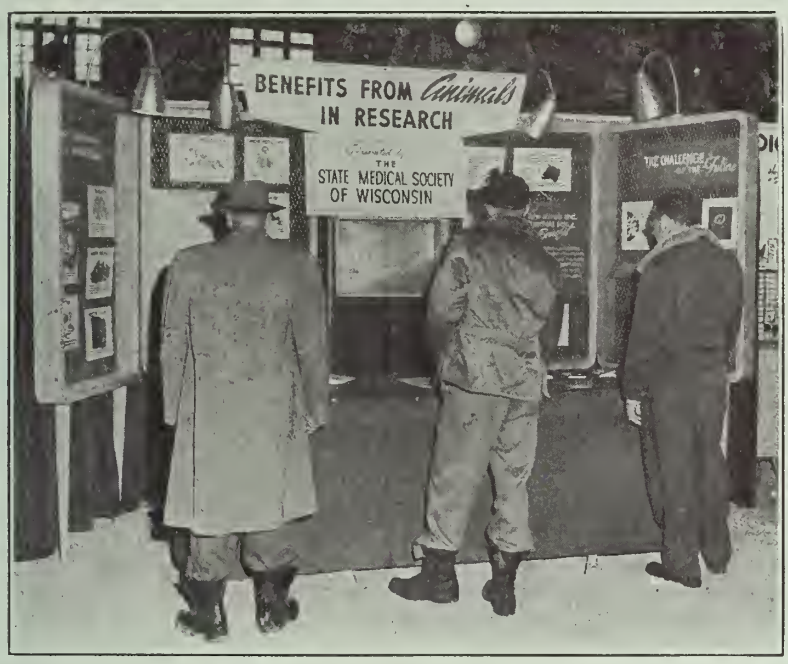
About 100 rural leaders, mostly women, heard the special program. Dr. MacCornack presented a discussion of the "Why and When of Health Examinations." Drs. Chester L. Kurtz and Kenneth B. McDonough of the University of Wisconsin medical school faculty explained problems of the diagnosis, treatment and care of rheumatic fever and heart disease victims.

Problems of rehabilitation and home care of the handicapped child were discussed by Miss Catherine S. Birdsall, physical therapist with the Department of Public Instruction, and Mrs. Mary Beyer of the Department of Vocational and Adult Education.

More than 8,000 pamphlets on cancer, heart disease, brucellosis, animal research and supply of physicians were distributed to those who viewed the exhibit or attended the health program.

RURAL WOMEN LEADERS hear Dr. Chester Kurtz, Madison, tell about heart disease at Farm and Home Week program sponsored by the State Medical Society, Feb. 8. Nearly 100 women were in the audience.

SEVERAL HUNDRED pamphlets were distributed to the audience of women which heard the Medical Society program at Farm and Home Week in Madison. Speakers (l. to r.): Dr. R. L. MacCornack, Whitehall; Dr. K. B. McDonough, Madison; Miss Catherine Birdsall, State Department of Public Instruction, and Mrs. Mary Beyer, State Department of Vocational and Adult Education.



MORE THAN 5,000 persons are estimated to have visited the State Medical Society's exhibit at Farm and Home Week in Madison, Feb. 4–8. They picked up over 8,000 pamphlets on various health topics during the five-day meeting.

Society Committee Studies Need for Visual Screening Program

Madison, Jan. 27.—Methods of providing visual screening programs for school children are being studied by the Committee on Visual Defects of the State Medical Society.

At a committee meeting on Jan. 27, physicians and representatives of the bureau for handicapped children of the State Department of Public Instruction agreed to:

1. **draw up a guide for medical direction of school vision testing programs.**
2. **survey county medical societies, school administrators and public health nurses to determine current practices in vision testing and conservation.**
3. **survey all eye-ear-nose-throat physicians for suggestions on a vision program.**

The committee includes Drs. J. B. Hitz, Milwaukee, chairman; E. J. Zeiss, Appleton; H. J. Belson, Manitowoc; T. J. Doyle, Superior, T. B. McNamara, La Crosse.

The committee is investigating the desirability of a program in vision testing comparable to the current hearing screening program currently used by schools in 65 counties.

Dr. Hitz emphasized that the committee contemplates a program that would utilize opthalmologists as medical advisors for all phases.

"Community" Plan

The program should be a "community" plan based on local resources and needs and utilize trained personnel of the bureau of handicapped children for consultation service in planning. The program would not begin until the whole project was adopted, including methods of follow-up and financing.

Army Expected to Call More Priority I Reserves

Washington, D. C., Feb. 4—An early announcement is expected concerning an Army call to active duty beginning in April for 180 Priority I physicians who already hold Reserve commissions.

Tri-County Society Offers Low-Cost Health Exam

Whitehall, Wis., Feb. 8—A low-cost "comprehensive" physical examination has been developed by the Trempealeau–Jackson–Buffalo County Medical Society, reports Dr. R. L. MacCornack, Whitehall, member of the State Medical Society's Council on Medical Service.

Dr. MacCornack is charged with responsibility for rural health programs as part of his council activities.

The examination is available at a cost of approximately $5 and is aimed primarily at the detection of cancer, although detection of other ailments and conditions is not overlooked. The $5 cost does not include x-rays or electrocardiograms.

CLAIM BLANKS

A Wisconsin doctor is likely to handle more TIME claim blanks than any other company's. TIME, a leader in the accident and health insurance field, insures a large portion of the total number of persons carrying such insurance in Wisconsin.

Few doctors appreciate the great service given to their patients when these claim forms are handled promptly.

Any suggestions from you as to how our claim forms may be improved will certainly be appreciated.

• • •

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FUTURE OF MEDICINE IN NORWAY IS "GLOOMY"

In this article, Dr. Gunnar Gundersen, La Crosse, member of the Board of Trustees of the American Medical Association, and an AMA representative to the recent World Medical Association meeting in Stockholm, concludes his report on medical care and economic conditions in the Scandinavian countries of Norway and Sweden. The first portion of his report appeared in the January, 1952, issue of the Medical Forum.

PART II

By DR. GUNNAR GUNDERSEN

In Sweden and particularly in Stockholm, hospital construction has had to be duplicated underground for fear of bombing by enemies. Consequently the two large hospitals in Stockholm, the Söder Hospital which is municipally run, and the teaching hospital of the Karolinske Institute, which is known as the Karolinske Hospital, is duplicated underground in solid granite, most of the institution being 20 to 30 meters underground. I think it can be said without fear of contradiction that there are no finer hospitals anywhere than these two hospitals in Stockholm.

In Stockholm I had an interesting conversation with a doctor whom I was led to believe is quite important in medical circles in Stockholm, and asked him the question, "What type of practice do you do?"

He told me, "I am a general practitioner."

On pursuing the question, "Well, what do you do specifically?"

"I am a general practitioner and take care of people who come to my office."

"Do you have any hospital connections?", I asked.

"No, I don't have any hospital connections. If patients must go to a hospital, I lose contact with them completely."

When I registered my surprise and asked him if he enjoyed this type of practice, he told me, "Of course I don't."

"If you had your own way about it, would you change the system?"

He said, "I certainly would."

I think the situation can be summed up briefly as far as both countries are concerned, in this way—that if one is willing to enter into the system and adjust oneself to the regimentation, one may be quite happy, but if one wants to carry on private practice as we understand it in this country, I believe he would find the greatest difficulty in succeeding or even getting anywhere at all.

In both countries there is a compulsory retirement age of 65. What a man can do after 65 is always a problem. Most of them are reconciled to accepting the rather modest pension and fading away completely from any activity in medical affairs.

Sweden has the same problem as far as distribution of medical services are concerned, as our antagonists in this country claim for medicine under the private initiative system.

Previously I mentioned that there is one physician to 1500 civilians in Sweden. In Norway, the ratio is approximately 1:1,000. Both countries are presumed to have excellent medical care under the government system. In Sweden one hears little of the lack of physicians. It is difficult to reconcile these figures with our own where we have approximately one physician to 800 population, and we hear constantly of physician shortage.

Getting back to the compulsory retirement at the age of 65, I can see that in many instances a grave injustice is worked upon these men who have a great deal to offer after the age of 65. Indeed, if we were to remove from our community the men over 65 in the practice of medicine, I think we would be depriving the citizens of many of its most important contributors in the field of medical practice.

The Scandinavian countries have gone the path of Socialism with the resulting steamroller squashing of the private initiative system almost completely. It is hard for me to believe that this type of government is suitable to our philosophy, exchanging for it a system which has made this country strong and the envy of the whole world.

In Norway and other countries, for instance, the people have great admiration for America. But they say, "For goodness sake, don't get sick over there. You can't afford it."

When I told them there is no reason why you could not insure

THE NEW SODERSJUKHUSET HOSPITAL in Stockholm. Most all hospitals in Sweden are owned by the municipalities or the Government. According to the American-Swedish News Agency, New York, which supplied the above photo, about 2,000,000 Swedes belong to the state-supported sickness insurance societies and "these are receiving free care, while others have to pay about 4 crowns a day including medicine."

WHOLESALE ORAL HYGIENE IN STOCKHOLM. Boys and girls from Stockholm schools have their teeth treated at the Dental Clinic. A New York camera manufacturer contributed $1,000,000 to its construction. Source: American-Swedish News Exchange, Inc., New York.

yourself against sickness and budget against the cost of sickness on a voluntary basis, this idea apparently never occurred to them. Apparently they give no thought whatsoever to the cost of sickness care. As long as it is paid for by the government, they suffer under the delusion that it is cheap and doesn't cost anything. I am sure of one thing, that it is not as cheap nor as efficient as the general public is led to believe.

"Exploit their Rights"

Many physicians in my own acquaintanceship, trained over there, who have seen our system, like the one that we have here in this country so much better that if they have an opportunity to stay here and work under our system, they invariably choose to do so. The ones who return do so by reason of loyalty to their country, or otherwise, the ones who have made their fortune in this country then choose to go back to live with the people of their own origin.

I had the distinct impression that there are plenty of nurses, something of which there is alleged to be a shortage in this country. We know that there are shortages in the service field of nursing but if it is true that of 500,000 nurses in this country, only 300,000 of them are actively engaged in practicing their profession, it seems to me that it becomes a question of trying to salvage some of the losses which occur in the nursing fields.

It seems to me that Dr. Peter M. Holst's observations are rather pertinent to the whole situation, conservative though he may be. The punch line, it seems to me, is the one which refers to the "differences in the civic sense of responsibility, giving support to the American point of view. Very many compulsorily insured persons seem inclined to exploit their rights to the utmost." Here is a report of his remarks:

Dr. Peter M. Holst, who is at the head of a section of the Oslo City Hospital at Ullevaal, recently gave an address in which he discussed both the influence of compulsory health insurance on the nation and the outlook for the medical profession. He pointed out that compulsory health insurance has expanded enormously since 1912, and that no political party in the country is likely to oppose the fundamental principles on which it is based. He said, in effect: Norwegian doctors are so familiar with health insurance that they ought to be able to give an opinion on it.

Sickness Rate is High

He claimed that voluntary health insurance is usually an expression of the qualities of responsibility and survival instinct, every wise and provident person being willing to offer much to avoid misfortune. But he queried the proposition that the same can be said of compulsory insurance, though he did not go so far as to insist that compulsory insurance has a directly destructive effect on these qualities.

Norwegian doctors are, however, in possession of considerable experience giving support to the attitude of the medical profession in the United States. Dr. Holst pointed out that, though the expectation of life has constantly increased in Norway, there has been no corresponding reduction in the sickness rate, to judge by health insurance statistics.

In Oslo, for example, the number of days for which monetary compensation was given for sickness rose per insured person from six in 1915 to 10 in 1947. The sickness rate in 1947 among some 41,000 male manual workers was nearly twice as high as it was among some 28,000 male office workers.

The sickness rate was approximately 50% higher among women

(Continued on page 192)

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MEDICINE IN NORWAY . . .

(Continued from page 191)

than among men, and among some 19,000 women manual workers it was about three times as high as among male office workers. The sickness rate was also much higher in the towns than in the country districts, and several times higher among persons enjoying compulsory insurance than it was among persons taking out voluntary health insurance.

These great differences do not reflect, in Dr. Holst's opinion, any corresponding differences in actual sickness rates, but differences in the civic sense of responsibility, giving support to the American point of view. Very many compulsorily insured persons seem inclined to exploit their rights to the utmost.

With regard to the future of the medical profession, Dr. Holst said that it has every reason to be gloomy, because there is a rapid deterioration of both economic and professional standards.

Goals of WMA

At the present time "no doctor is able by his work as such to assure himself a care-free old age." Even those who can look forward to a pension in their old age know that it will be inadequate for the maintenance of their former standard of living. So many doctors are obliged to cling to a practice which gradually diminishes with advancing years.

At the present time, some 10% of Norwegian doctors are over the age of 70; this percentage is bound to rise. The younger doctors who wish to specialize often find the road blocked by competition. In Dr. Holst's own section of the Oslo City Hospital, there were recently so many applicants for appointments to be held by would-be specialists that it would have taken some ten years to give all of them their chance."

The World Medical Association serves some very good and necessary purposes. I shall enumerate them, not necessarily in order of their importance.

1. It has the opportunity of establishing a code of ethics for the entire medical profession. The convention of Geneva which was adopted a few years ago sets down principles of ethics which may well serve as a guide to the doctors of the entire world, and should be adopted as the code in the participating countries.

2. It has great importance in the field of medical education. An effort should definitely be made to establish a base for pre-medical education and medical education, so that a doctor, regardless of the country of his origin, will have at least a minimum basic training.

3. The W.M.A. can serve as a clearing house for world medical literature. I can foresee a great future in this field. There is no other agency now in existence which can serve as a clearing house for the medical literature of the world.

4. The World Medical Association serves as a forum for the physicians of the world, and I believe this one is probably the most important function.

WMA Vastly Important

It is to be remembered that the other forum, the World Health Organization, is a governmental agency made up of representatives of governments who are interested in health problems generally, and is not necessarily representative of physicians' thinking in the participating countries. Its opinions are necessarily colored by the types of governments which the delegates to W.H.O. represent.

The World Medical Association, however, is made up of the duly constituted representatives of the organized profession in the world, and consequently can speak authoritatively for medicine.

This is important. I think the W.M.A. can make its voice heard and felt in the various health organizations of the world, and I can foresee a great benefit to the human race as a result of its deliberations.

It was interesting to note that there was very little difference of opinion as far as the physician representatives were concerned in regard to the whole field of social security.

I got the distinct impression that even the representatives from the Socialist countries felt that the pendulum had gone altogether too far in the whole field of social security, particularly as social security pertains to free medicine. The individual responsibility is gone. The net effect is demoralizing on the soul of the people who accept it for long.

MIGRANT WORKERS . . .

(Continued from page 187)

after treatment is started, and in continuing treatments begun in another state before they arrive in Wisconsin.

Present were Drs. D. E. Dorchester and J. C. Pinney, Sturgeon Bay; H. J. Kief, Fond du Lac; E. G. Nafziger, Oxford, and Harold Coon and C. N. Neupert, Madison.

Others included Herbert Smith, of the State Employment Service; Mrs. Rebecca Barton of the Governor's Commission on Human Rights; Miss Jenny Lind and George Keith of the Department of Public Welfare; Miss Maude Swett and Harry Nelson of the Industrial Commission, and Marvin Verhulst of the Wisconsin Canners Association.

Most migrants are Mexican citizens of Texas. Some are southern Negroes, Kentucky and Tennessee whites, and a few are South Dakota Indians.

Physicians from Door, Columbia, and Fond du Lac counties report the most difficulty. Workers from southern United States are more of a problem than foreign workers because those who come from Mexico and British West Indies are screened to weed out those with tuberculosis, venereal disease and other conditions which make them medical liabilities in the community where they work.

Plan Drive for Medical School Funds

Chicago, Feb. 18—The 1952 campaign for funds on behalf of the American Medical Education Foundation will be held from April 15 to June 30.

Plans were discussed in detail at a meeting of representatives from 48 states on February 17.

R. F. Staudacher, the foundation's executive secretary, said the campaign will seek $5,000,000 from physicians during 1952 for support of the nations medical schools. Business and industry are expected to contribute even more.

The foundation's first year ended December 31 with more than 1,800 individual physicians contributing a total of $746,000. As it did in 1951, the A.M.A. has contributed another half million dollars to serve as a nucleus for the 1952 campaign.

FITZGERALD URGES END TO COMPULSORY RETIREMENT

Chicago, February 11.—America has made such a cult of youth that millions of older workers face a tragic economic and social future, Dr. Robert E. Fitzgerald, Milwaukee, warned the National Conference on Medical Service in Chicago.

The conference is made up of officers of state and county medical societies and meets annually to discuss major socio-medical problems. Dr. Fitzgerald was president of the conference at the time of his address.

"There is a completely unrealistic haze of sweetness and light over our nostalgic picture of the old family unit occupying its own home with the elders serenely enjoying the fruits of their labors in quiet contentment," Dr. Fitzgerald said.

Today the elders are more apt to live in a tiny apartment or a small bungalow. A pitifully small minority have succeeded in saving enough money for their older years during these days of increased taxation and spiraling living costs, he asserted.

Birthdays Penalized

This has come about through no disability of their own, Dr. Fitzgerald declared, but only because most public and private business has developed a policy of compulsory retirement at 65. A man is penalized for his birthdays with complete disregard for his ability, Dr. Fitzgerald contended.

He asked for an end to compulsory retirement policies and thrifty use of already trained workers without endangering the advancement of the younger man in industry.

Need Educational Programs

He also suggested planned programs for the part-time employment of those who are over age but not able to carry the full burden of their previous jobs.

Dr. Fitzgerald proposed the establishment of employment agencies for elderly folks and the promotion of educational programs to encourage retired people to cultivate hobbies which would not only add to their zest for life, but might also increase their incomes.

Wisconsin Doctors Highlight National Medical Conference

DR. R. E. FITZGERALD

DR. J. S. SUPERNAW

Supernaw Says Veteran is Handicapped by VA Red Tape

Chicago, February 11.—A plea that the Veterans Administration end its paternalism and permit the veteran free choice of physician and hospital care was voiced by Dr. J. S. Supernaw, Madison, at the National Conference on Medical Service in Chicago.

Dr. Supernaw called the VA's hospital building program "alarming, to put it mildly." He said the VA plans to increase its hospitals by 5,800 new beds within a few months. He charged that this will create serious nursing and doctor shortages in civilian hospitals.

At present, the VA permits limited free choice of physician and hospital through an intermediary arrangement operating in 12 states, Wisconsin among them. Under the "home town medical care program" veterans with service connected disabilities may go to the physician of their choice in their own community for medical treatment.

Doctors Like Local Plan

Under the home town plan, the VA contracts with the Wisconsin Veterans Medical Service Agency of the State Medical Society, of which Dr. Supernaw is chairman, to handle the clerical and administrative part of the medical program. Periodically the VA reimburses the agency for professional services for veterans in addition to making an allowance for the cost of administration.

Both physicians and veterans like this plan, according to Dr. Supernaw. The Wisconsin agency questions about 50 veterans each month for their opinions of the home town program.

About 99 per cent respond favorably, stressing particularly the fact that it permits them to receive care locally "from a doctor who knows my case" and without the necessity for travel to another city for treatment.

Doctors like the system because it eliminates much red tape. Even so, Dr. Supernaw charged that the Veterans Administration seems to think that "time and paper work are more important than the veteran."

Dr. Supernaw said it is not uncommon that benefits are denied a veteran because the doctor forgets to send in the proper form within the 15 day limit after rendering service.

"It is a little difficult to explain why the doctor won't be paid and the veteran denied the benefit just because the doctor was so busy that he didn't get his paper work in on time, even though the disability was service connected and the doctor rendered adequate care."

Nearly 700 Americans Enrolled in Foreign Medical Schools

Chicago, February 12.—A significant enrollment of American students in foreign medical schools was reported to the Council on Medical Education and Hospitals at a meeting in Chicago, February 12.

Dr. Francis R. Manlove of the A.M.A. reported on a survey which disclosed that 671 American students are currently enrolled in 50 foreign schools. He pointed out, however, that there are indications that the number may greatly exceed that revealed by the survey.

Most of the students are enrolled in Swiss schools with schools in the Netherlands, France, Ireland, Germany and Italy ranking high on the list.

He indicated that most of these students had previously been refused from medical schools in America or were unable to gain admittance.

He said that the medical school at the University of Paris has 6,988 students, 31 of which are Americans. Twenty-six Americans are enrolled in an Havana medical school which has a total enrollment of 3,392.

Dr. Manlove urged medical examining boards to consider seriously the problem that will be presented within a few years when these students return to America and seek licensure for practice.

Death Overtakes Former Congressman Keefe

Washington, D. C., Feb. 11—Republicans and Democrats alike joined in eulogy to Frank B. Keefe, former Congressman from Oshkosh, Wisconsin, who died recently.

High tribute was paid to the 12-year record achieved by the stern, yet understanding Republican as a Representative from his state's 6th District, particularly for his efforts in behalf of federal support of medical research.

Rep. John E. Fogarty (D., R.I.), said. "He was a strong opponent of socialized medicine, but he was at the same time a strong advocate of federal expenditures for research in the leading causes of death."

NEW PLAN TO AID MEDICAL SCHOOLS

Chicago, February 12.—A new plan which promises to be a substantial source of private funds to finance medical education was disclosed in Chicago by Dr. John W. Cline, San Francisco, president of the American Medical Association.

Speaking at the Congress on Medical Education and Licensure, Dr. Cline disclosed that the Board of Trustees of the A.M.A. has approved in principle a plan whereby the association, as a corporation, would accept patents for medical discoveries made by member physicians.

All royalties would be turned over to the American Medical Education Foundation for distribution to medical schools.

At the same time he warned medical schools against becoming "perpetually dependent on Washington handouts."

New Hospital Wing Realizes Keefe Dream

Madison, January 23.—A new wing for University of Wisconsin hospitals came to life on January 23 when federal and state dignitaries participated in the dedication of the new cancer section of Wisconsin General Hospital.

Frank B. Keefe, Oshkosh, former congressman from Wisconsin's sixth district, told of his battles with the Bureau of the Budget to obtain federal research aid for the new medical center.

"It is one of the greatest pleasures of my life to see the realization of a dream here today," he said.

Dr. Leonard A. Scheele, surgeon general of the U. S. Public Health Service, called cancer research leadership of Wisconsin "high order." The Public Health Service granted the $975,000 that made the cancer wing possible.

Also participating in the dedication were Gov. Walter J. Kohler, University President, E. B. Fred, Regent President, F. J. Sensenbrenner, and Medical School Dean William S. Middleton.

Commissioner Explains Harrison Law

Chicago, February 12.—Synthetic analgesic drugs are addicting as well as pain-relieving and the same care should be exercised in their use as in the prescribing and dispensing of morphine, warns H. J. Anslinger of Washington, United States commissioner of narcotics.

In a paper read before the annual Congress of Medical Education and Licensure in Chicago, he also cautioned doctors to guard against the diversion of narcotics prescribed for patients suffering from a malignant condition. He urged that the physician administer no more of the narcotics than is necessary to achieve the desired result.

Patients requiring daily administration should be seen often by the doctor and the amount of drugs ordered or supplied should not exceed that required by the patient until seen again.

He cautioned doctors about the provision of the Harrison law that limits all prescribing, administering and dispensing of narcotic drugs to "the course of his professional practice only."

Mr. Anslinger said this was intended to confine the immunity of a licensed physician strictly within the appropriate bounds of professional practice. It does not extend to the sale of drugs to a dealer or distribution intended to cater to the appetite or craving of one addicted to the use of drugs.

A "prescription" issued for either of these purposes protects neither the physician who issues it nor the dealer who knowingly accepts or fills it, Mr. Anslinger emphasized.

VA Reports 30.8 Days is Average Hospital Stay

Washington, D. C., Jan. 29—The Veterans Administration, reporting to Congress on its operations for 1951, said that 65% of its cases were non-service connected.

Eighty-seven per cent received general medical and surgical treatment. The average stay for general medical and surgical patients was 30.8 days, and the average cost per patient per day was $16.47.

Clinicopathologic Conference

Editors—W. A. D. ANDERSON, M. A., M. D., Marquette University School of Medicine, Milwaukee and D. M. ANGEVINE, M. D., University of Wisconsin Medical School, Madison

PRESENTATION OF CASE*

J. N. was a 67 year old white male who was admitted to hospital in deep coma. A brother of the patient gave the following history:

For a period of more than six months before admission the patient had been troubled with intermittent abdominal pain. This was described as cramping in character, quite severe, and coming on within 30 minutes after eating and particularly after "heavy" foods. Pain was located in the epigastric and umbilical areas and did not radiate. Occasionally it was accompanied by a diarrhea which developed shortly after the ingestion of food. When the pain was particularly severe, non-bloody diarrhea would develop within five minutes after eating and especially when meat was a prominent item in the diet. Progressively the condition became worse, and severe intermittent pain was common after most of the meals. The patient was much relieved by a strained baby food diet. However, the illness continued, and there was a 50 pound weight loss during this interval of time. Three gastrointestinal x-ray examinations were "negative."

Four days before admission to the hospital the patient went to bed and refused food and fluids. He gradually became quite weak, then irrational, and finally went into a deep coma. During the four days before admission no urine was passed.

Physical examination revealed a pale emaciated white male who was in deep coma and who showed a weak slow pulse accompanied by shallow rapid respirations. The eyeballs were soft and the pupils did not react. The lungs revealed bilateral bubbling rales. The heart was not enlarged. It was difficult to auscultate since the tones were almost inaudible. The abdomen revealed no palpable masses, no rigidity, or tenderness. The bowel sounds were hyperactive at times. Rectal examination revealed brown, formed stool. Blood pressure was 40/20, pulse 60, and temperature 97 F.

Laboratory Data.—Urinalysis revealed 2 plus albumin and occasional granular casts. Red blood cell count was 2,790,000, white blood cell 4,650, hemoglobin content 58 per cent, color index 1.0, and differential 65 per cent band forms, 21 per cent segmented forms, 1 per cent eosinophils, 6 per cent lymphocytes, 1 per cent monocytes, 2 per cent neutrophilic metamyelocytes, and 4 per cent neutrophilic myelocytes. Also present were 21 normoblasts per 100 white blood cells, toxic degeneration of the polymorphonuclear cells, marked anisocytosis, and moderate macrocytosis. Nonprotein nitrogen was 141 mg., sodium chloride 454 mg. (whole blood), and alkaline reserve 45.6 vol. per cent. Blood group was 0, Rh positive.

* From Milwaukee County Hospital; **Dr. F. D. Murphy**, clinician; **Dr. J. L. Marks**, radiologist; and **Dr. J. F. Kuzma**, pathologist.

Roentgenographic Findings

Dr. J. L. Marks: Several small intestinal series were done on this patient in another hospital and were reported as negative. I have reviewed these films and would agree with the examiner's interpretation. Esophageal, gastric, duodenal and colonic lesions are readily studied by roentgenographic means. Small bowel examinations, however, are not as successful. In this case with persistent gastrointestinal symptoms but with three negative roentgenographic examinations, one would become aware of the possibility of a small bowel lesion.

Several different methods of examination to determine the presence of small bowel disease are used. One is the small bowel barium meal method in which frequent films are taken at intervals of approximately one-half to one hour with multiple spot films. The small intestinal enema as originally described by Shatski, and the triple lumen double-balloon tube method as originally described by Abbott and co-workers and more recently by Freidman and Rigler, are useful adjuncts to the conventional small bowel barium meal study. When one realizes that over 25 feet of small intestinal tract must be studied by means of the barium meal, it is easily understood that areas of disease can easily be overlooked even on repeated roentgenographic series. The overlapping of small bowel segments is the frequent cause for failures of adequate radiologic demonstration.

Small bowel lesions that must be differentiated are avitaminoses, sclerosis of scleroderma, tuberculosis, lipoid dystrophy, segmental regional enteritis, and tumors such as lymphosarcoma, myosarcoma, etc. Of these, regional enteritis is most likely to lack demonstrable changes.

Regional enteritis was originally described in 1932 by Crohn and co-workers[4] as a clinical entity under the term of regional ileitis; however, since this original description the pathologic process of this entity has been described in all segments of the small bowel. Hence, the term regional enteritis is more accurate than the original name of terminal ileitis. Regional enteritis is usually diagnosed radiologically by a narrowing of the involved segment which may vary from 2 mm. to 3 or more feet in length. Not infrequently multiple areas are found which show involvement between segments of normal intestines.

The narrowed segment is frequently irregular in caliber with an absence of the usual mucosal folds in the area of involvement. Some of the narrowing is not due to intrinsic lesions of the involved segments alone but to an associated spasm of the granulomatous area. In some instances the narrowing may become rigid enough, secondary to fibrous constriction, so that a mechanical ileus will occur. Occasionally, fistulous communications will occur between an involved segment or segments and a previously normal loop of small bowel.

Ross Golden of Columbia Hospital, New York City, has also described a lesion known as "non-sclerosing ileitis." The essential difference in this particular lesion is the failure of constriction of the involved segment, and he has termed the abnormalities of the mucosa of this pathologic process "the cobblestone ileum." These changes in non-sclerosing ileitis have been recognized for the last 15 or more years and none of these patients has subsequently developed typical sclerosing regional enteritis. Therefore, it seems probable that this is not the same disease process as regional enteritis, and the term non-sclerosing ileitis is suitable for this particular lesion. Tuberculosis of the terminal portion of the ileum must also be differentiated from regional enteritis. The association with pulmonary tuberculosis is strong presumptive evidence that the small intestinal disease is of tuberculous origin. Involvement of both the ileum and cecum suggests tuberculosis; however, cases of regional ileitis with an associated involvement of the cecum have also been described. Carcinoma of the small bowel may give a similar picture, but this lesion is of infrequent occurrence.

Clinical Discussion

Dr. F. D. Murphy: The history in this case is quite inadequate as the information was obtained not from the patient but from his brother. The absence of a reliable history always constitutes a serious handicap in diagnosis. We do know, however, that the patient appeared to be quite well until six months prior to hospital admission at which time he complained of abdominal pain, loss of weight, diarrhea, and gas. No exact diagnosis of a debilitating condition was made. Opportunities for close observation and study were not available as the patient lived only a few hours after admission. However, with the scant history, physical examination, and laboratory findings at hand, I shall endeavor to make a diagnosis.

The physical examination and course in the hospital emphasize the following points: (1) The patient lost an excessive amount of weight, was emaciated and anemic. (2) Examination of the heart, lungs, and abdomen revealed no evidence of disease. We are left then with a patient who had two outstanding clinical syndromes: (A) Apparently, there is some disease of the bowels as diarrhea was a prominent symptom; and (B) The urinalysis revealed heavy albuminuria, but no red blood cells or pus cells were found. As the nonprotein nitrogen was 141 mg. per cent, one would think perhaps that renal insufficiency was the primary disorder. With such a picture, one of several types of renal disease may be responsible for the azotemia and albuminuria; for example, in a patient with a serious gastrointestinal lesion leading to excessive diarrhea and dehydration, the azotemia and albuminuria may be due to so-called "extrarenal" uremia. This diagnosis is made when a patient has been suffering from excessive vomiting and diarrhea or some grave antecedent disorder. Another feature of extrarenal uremia is its easy control by the use of adequate amounts of fluid. Time was not available in this case to make such observations. Secondly, azotemia and albuminuria of this type occur in acute or subacute glomerulonephritis or in connection with certain poisons of the heavy metal type. A study for arsenic was made but the absence of red blood cells, pus cells, and casts would be against this kind of a renal disease. Thirdly, it has to be kept in mind that such a condition may occur in association with generalized collagen diseases such as lupus erythematosus, periarteritis nodosa, and rheumatic fever, but there is no evidence to indicate that any one of these forms of disease is present.

It is now popular to describe certain rare and unusual types of nephritis which occur in connection with ulcerative colitis and other inflammatory diseases. Baggenstoss and associates described a case of subacute glomerulonephritis found at autopsy with evidence of endocarditis of the Libman–Sacks variety. Kulka and associates[2] have also recently described a degenerative disease of the kidney in connection with regional ileitis. However, I would not wish to make a diagnosis of these rarer forms of nephritis as the precise diagnosis of the intestinal lesion is not at hand, and there is no evidence of lupus erythematosus or periarteritis nodosa.

If pressed for a final diagnosis, I should say that this patient probably had some form of subacute nephritis, as the whole disorder is of less than six month's duration and perhaps the same disturbance which caused the gastrointestinal disorder is the causal agent for the renal disorder present. The classical syndromes of subacute glomerulonephritis are not present, *i.e.*, hypertension, edema, and hematuria, but, of course, nephritis may not show all of these syndromes at the same time. Although I am not certain of the nature of the nephritis, I would consider it the most likely diagnosis because whenever one encounters albuminuria and azotemia, the most likely thing is some form of nephritis. The most logical conclusion would be that the kidney is the organ most severely damaged and is responsible for the patient's death.

Pathologic Discussion

Dr. J. F. Kuzma: There was no free peritoneal fluid present. The small bowel was prominent because of its opaque character. The loops varied

from 2 to 3 cm. in diameter. The serosal surface of the small bowel was milky-white in color, and there was very marked opacity along the mesenteric attachment. The bowel wall was visibly and palpably thickened and somewhat increased in consistency. All the segments had a peculiar doughy sensation. A number of the loops were reddish-brown on the external surface and marked by prominent injection of the superficial vessels. A very fine granularity was noted in these areas. Such segments extended from 3 to 10 cm. in length. In several of these areas there was an opaque white band about 1 cm. in width encircling the bowel and producing an externally visible constriction. On removal of the gastrointestinal tract it was noted that the first 18 inches of the jejunum were bile-stained and comparatively thin-walled. From this point on to within 18 or 20 inches of the cecum, the opaque thickened heavy bowel wall as described above was noted. Upon opening the bowel much of the serosal reddish-brown discoloration of various segments was lost. Examination of the mucosal surface showed a moderately edematous thickening of the mucous membrane of most of the jejunum and proximal ileum. There were 13 areas of mucosal ulceration found in the length identified on external examination as abnormal. Nine of these ulcerations measured approximately 1 cm. in width, were completely circumferential, had produced approximately two-thirds to one-half narrowing of the bowel circumference, and corresponded to the external markings of constriction. The ulcerated zones, however, showed a thick, opaque, white, but moist and pliable, change in the submucosa. The muscularis in these zones was thinner than in adjacent areas. These ulcerations were separated from each other by variable distances. Three were within 2 to 3 cm. of each other; whereas, others were separated by as much as 15 to 20 cm. The mesenteric lymph nodes were rounded, edematous, moderately firm, and grayish-pink in color.

The combined weight of the kidneys was 360 Gm. The capsules were loosely attached and the cortical surfaces were very pale, smooth, and glistening. Occasional pin-point brownish-red dots were seen on the external surfaces. The average thickness of the parenchyma was 13 mm. with the cortex ranging between 5 and 6 mm. The cortical arches were pale in color but on close examination showed very small pin-point reddish-brown dots. The medullary rays were in sharp contrast by their deep congestion. The pelves and calyces revealed occasional petechial hemorrhages. The renal vessels were moderately sclerotic.

The heart weighed 350 Gm. The myocardium was very soft and deep brown in color. The epicardial fat tissue showed severe atrophy. The valvular apparatus showed no significant change.

The liver weighed 1070 Gm. It was deep brown in color, finely granular, and soft in consistency.

The spleen was 45 Gm. in weight, moderately congested, and without definable follicles.

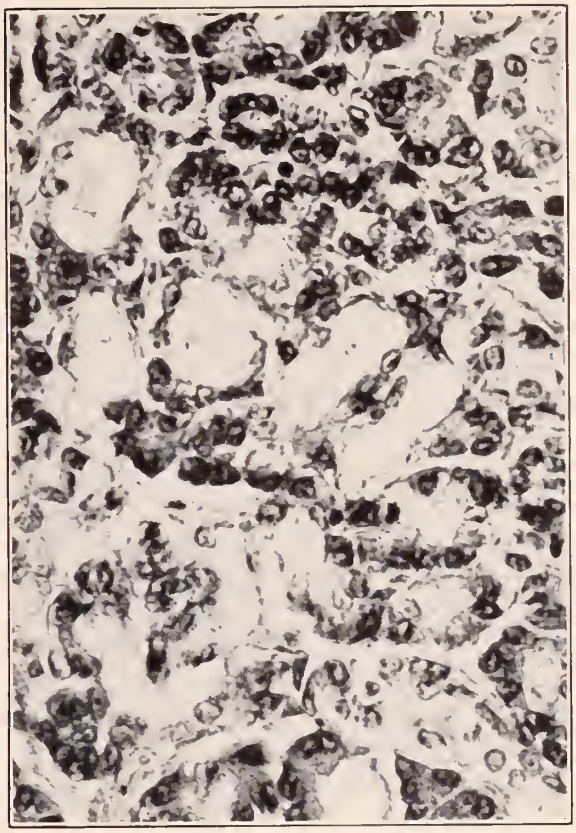

Fig. 1.—Photomicrograph of pancreas, showing acinar dilatation.

Histologic examination showed advanced brown atrophy of the liver and myocardium with mild interstitial myocarditis. The sections of small bowel showed the pattern of marked submucosal fibroinflammatory reaction, varying in degree of development and proportion of inflammation and fibrosis. Many areas showed a spongy connective tissue punctuated by lymphoid cells with occasional plasma cells. Other areas showed more prominent inflammatory cell groups which in one were composed of large mononuclear cells having an epithelioid orientation. In many of the sections the mucous membrane was absent, and the thickened submucosal fibrous tissue was the seat of ulceration. The serosal areas of the bowel were considerably thickened. All vessels of the bowel were moderately dilated. The muscularis was without significant change, and the mucous membrane outside the ulcerated zones was without distinctive alteration although considerably infiltrated by plasma cells. The pancreas showed enlargement of the lobules and marked glandular formation of acini. Many of the acini contained pink granular material and were enlarged to lobular duct size. This dilatation of the acini was accompanied by flattening of the cells and evident epithelial atrophy in some of the zones. The islet tissue was not involved.

The kidneys revealed marked pallor of the cortical tissues which was produced by changes in the

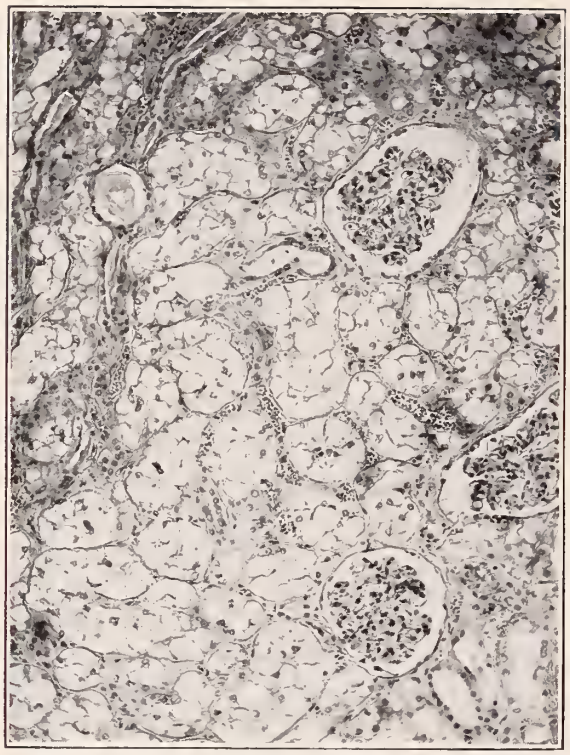

Fig. 2.—Photomicrograph of kidney, showing vacuolar swelling of convoluted tubule lining cells.

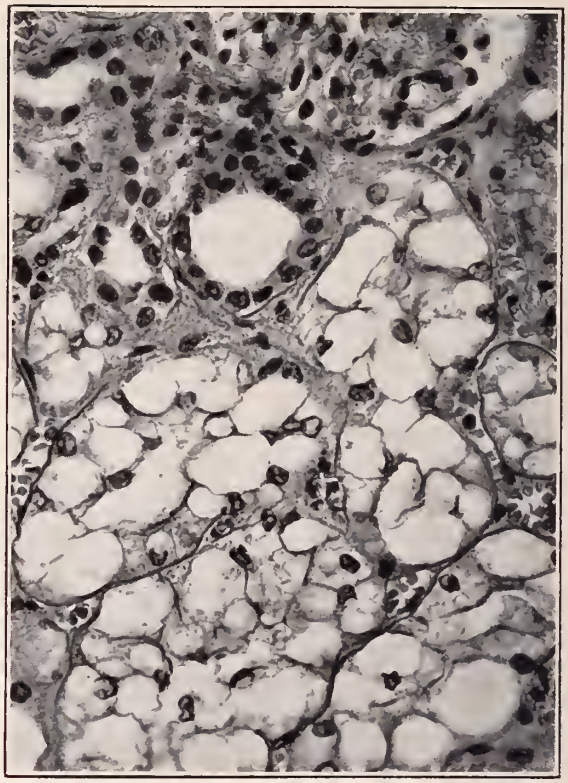

Fig. 3.—High power photomicrograph of kidney, showing vacuolar swelling of tubular lining cells.

proximal convoluted tubules. Many of these were dilated and their epithelial cells were spherical and ballooned with exceedingly large vacuoles. The nuclei were generally round or somewhat flattened but eccentric in position. Many of the cells had a signet appearance although the flattening of the nuclei was not extreme. There was accompanying desquamation and in some instances lysis. Minor degrees of vacuolization were noted in some of the cells, but generally it was severe. Usually only single vacuoles were found in the cells. The distal convoluted tubules and collecting tubules were not involved by this process. The glomeruli were rather small in comparison to the dilated convoluted tubules. They were deeply congested, and except for albuminous material in Bowman's space showed no particular change.

The brain showed prominent perivascular and pericellular edema. The bone marrow showed marked atrophy of its cellular components and a gelatinous character of the fatty tissue.

Our findings, therefore, were those of *regional enteritis* accompanied by a severe *hydropic vacuolar tubular nephropathy* and *cystic glandular dilatation of the pancreatic acini.* Minor associated changes were those of advanced *brown degeneration of the myocardium and liver.*

The association of renal change with diseases of the bowel has been pointed out by Baggenstoss and associates[1] and more fully reported by Kulka.[2] In our case special histochemical examinations of the kidney failed to identify the character of the tubular vacuolization. It has been concluded by others that the vacuoles represent a watery change, and the condition is known as hydropic vacuolar nephropathy. Its precise mechanism of development is unknown, but it probably has something to do with the electrolyte disturbances developing in instances of chronic diarrhea. The pancreatic lesions of uremia, chronic vomiting, or diarrhea have previously been described by Baggenstoss and his group.[3] The cystic glandular pattern in this case is an excellent example of that entity. It is suggested that severe dehydration following such gastrointestinal disturbances leads to inspissation of the pancreatic secretion and to obstruction of the minor ducts leading to acinar dilatation. The anemia and leukopenia have also been previously described with particular reference to the hepatosplenic complex as seen particularly in chronic ulcerative colitis. In such a condition a toxic cirrhosis and "hypersplenism" may develop.

The clinical features of the case presented here are not sufficient to suggest a diagnosis. However, the history of epigastric and umbilical pain following heavy foods which was accompanied by severe non-bloody diarrhea shortly after eating might, however, suggest enteritis. However, if one adds to this part of the story the relief of symptoms on ingestion of strained baby foods and the fact that three gastrointestinal x-ray examinations were reported negative, one might have strong evidence for the diagnosis of regional enteritis. The develop-

ment of azotemia and uremia with such a background would probably be interpreted as extrarenal uremia due to loss of fluid and electrolytes from the bowel. The hematologic picture of anemia and leukopenia accompanied by normoblastosis is an expression of the activity of the spleen accompanied by bone marrow atrophy in this metabolic disturbance. Therefore, again we are reminded of the intricate relationships of organ systems.

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UNIVERSITY OF WISCONSIN MEDICAL SCHOOL ANNOUNCES POSTGRADUATE COURSE

A postgraduate course on "Recent Advances in Prevention and Therapy of Infectious Diseases" will be presented by the University of Wisconsin Medical School on March 18, 19, and 20. The program will be presented under the direction of Dr. John W. Brown, professor of preventive medicine and director of the department of student health.

This course includes presentation of patients, as well as lectures, a clinical pathologic conference, and an x-ray conference. An attempt has been made to cover the more important aspects of the field of infectious diseases in a way that would be most beneficial to the physician in general practice.

The course is scheduled as follows:

Tuesday, March 18

8:00 Registration and Introduction—Doctor Brown
9:00 *Immunity—Current Concepts*
1) Mechanisms—Dr. C. V. Seastone
2) Hormonal Influences—Dr. E. S. Gordon
10:00 3) Nutrition—Dr. P. F. Clark
4) Immunization—Dr. J. E. Gonce
11:15 *Antimicrobials in Use Today*
1) Pharmacology—Dr. J. E. Steinhaus
2) Some Basic Principles—Dr. A. F. Rasmussen
2:00 *Antimicrobials—Clinical Use*
1) Indications; Methods of Administration—Dr. O. O. Meyer
3:00 2) Dangers, Precautions; Prophylactic Uses—Doctor Brown
4:00 Clinical-Pathologic Conference—Dr. D. M. Angevine and Staff

Wednesday, March 19

8:00 ROUNDS (Presentation of patients from wards, illustrating typical problems)—Staff
Room in Hospital to be announced
9:00 *Viral Infections*—Doctor Rasmussen
10:00 *Animal-Human Diseases*—Drs. R. P. Hanson and R. W. Quinn
11:15 *Urinary Tract Infections*—Dr. J. B. Wear
2:00 *The Pneumonias*—Dr. W. S. Middleton
3:00 *Streptococcic Infections and Rheumatic Fever*—Doctor Quinn

Thursday, March 20

8:00 ROUNDS (Presentation of patients from wards, illustrating typical problems)—Staff
10:00 *Granulomas* (Brucellosis, Tularemia, Systemic Mycoses)—Drs. Helen A. Dickie and Brown
11:15 *Essential Laboratory Procedure*—Dr. W. D. Stovall
2:00 *Antiseptics, Aerosals, and Other Physical-Chemical Methods of Control of Infections*—Doctor Seastone
3:00 *Biological Warfare Defense*—Drs. C. N. Neupert and W. B. Sarles
4:00 X-Ray Conference—Dr. L. W. Paul and Staff

Advance registration for the course is required as the program is limited to 30 registrants. Tuition for the course is $10, and all communications should be addressed to Dr. Robert C. Parkin, 418 North Randall Avenue, Madison 6, Wisconsin.

Facts about

Blue Shield of Wisconsin

an agency of the State Medical Society of Wisconsin

Prepared by the Directing Board of Blue Shield of Wisconsin, an Agency of the State Medical Society of Wisconsin, E. M. Dessloch, Prairie du Chien, Chairman.

Ask Your Patients for Identification Card

When a patient tells you that he has Wisconsin Physicians Service protection, ask him to show you his Blue Shield identification card. If your secretary handles these matters, tell her to ask patients for this card.

This card not only positively identifies the subscriber or dependent as a holder of Blue Shield coverage, but it provides important information for your Physicians Service Report (claim blank) to the Wisconsin Physicians Service office.

The identification card is issued only to the subscriber. When care is rendered to dependents of the subscriber, they should be asked to obtain the card and show it to you.

Positive knowledge on your part that the patient has Blue Shield coverage will eliminate rejections of PSRs submitted by you in good faith for patients who actually do not have the Blue Shield plan. Some persons confuse Blue Shield with Blue Cross. They believe that Blue Cross covers not only hospitalization bills, but also doctor bills.

A recent review of rejected Physicians Service Reports in the Wisconsin Physicians Service office revealed the interesting fact that 10 to 20 claims are turned down each week because the patients are not Blue Shield subscribers and never have been.

Proper completion of the Blue Shield Physicians Service Report requires much of the information contained on the identification card. This information is particularly essential when services have been rendered to patients in the home or office or elsewhere outside a hospital.

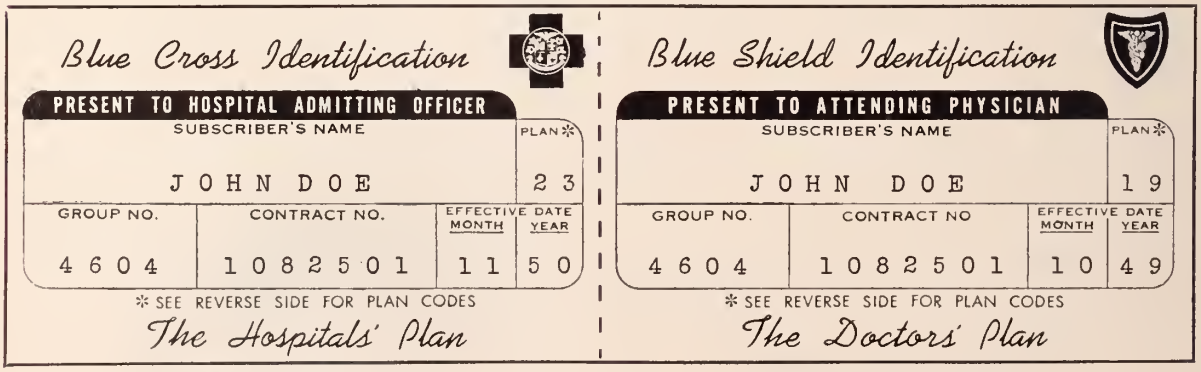
When you or your secretary see the identification card, copy off the following information:

1. Group number
2. Contract number
3. Name of subscriber

At the same time you ask the patient to show you the identification card, be sure to obtain the name of the patient, relationship of patient to subscriber, and address of subscriber. This information is needed for the Physicians Service Report form.

More than 550,000 persons in Wisconsin are now covered by Blue Shield for the express purpose of providing financial assistance to them in the payment of expenses incident to serious illness or injury. Asking the patient to show his Blue Shield identification card should cause no more embarrassment than that occasioned by the department store clerk who requests a charge plate when you wish to purchase something on account.

Physicians Service Reports sent in for patients who are not Blue Shield subscribers or dependents cause confusion, misunderstanding and loss of valuable time for both the doctor and the Blue Shield staff. So, ask your patients for their Blue Shield identification cards the first time they come to you for professional services.



This is the Blue Cross Identification Card

This is the Blue Shield Identification Card

When a patient shows both of these cards (they are attached in the center) he has both Blue Cross and Blue Shield coverage. Separate cards are issued when only one coverage applies. Be sure you or your secretary ask for Blue Shield identification.

. . . . THE PRESIDENT'S PAGE . . . .

Three Lessons in Practice

IF THE stories told to the Grievance Committee could be translated into fables and the writer could end them with a statement of the lessons they taught, as Aesop did, they would make interesting reading and all of us could learn much from them.

Of course this is impossible because of the confidential nature of this committee's work, but I would like to tell you about some of the things that were brought out in the meetings I have attended.

When things go right the doctor stands just below God in the opinion of the patient and those about him.

When things take a turn for the worse, everyone becomes critical and every word spoken by the doctor, his assistants, the nurses and interns, to allay the anxiety and fears of the patient and relatives, may be interpreted as being employed to cover up alleged mistakes by those attending the invalid. Explanations using medical terms, which are commonplace and perfectly understood by medical men, are often misinterpreted and misunderstood by laymen. The results are unfortunate and often lead to misunderstandings which are serious.

Lesson—Guard well your tongue.

Complaints about medical charges often result from the fact that the cost of medical care has not been explained to the patient either before or after the treatment is rendered. Patients feel that, except in emergencies, they have a right to a reasonably accurate estimate of what an elective procedure will cost so that they can prepare to meet the payment when it is due. In medical cases itemized statements will tell them why and what for, as well as how much.

Lesson—It is easier to pay a medical bill and easier to collect a medical fee when the why and what for are fully explained.

Some of the cases which come before the committee result from disparaging remarks made by a fellow practitioner of medicine. All of us know that in some cases factors beyond the control of the attending physicians make it impossible to obtain a perfect result in a given case. We should be charitable and not give opinions until we know all of the facts. Unfounded criticism of any doctor affects public opinion concerning the entire medical profession.

Lesson—Do unto your fellow practitioners as you would have them do unto you.

The Grievance Committee has no jurisdiction over cases of actual malpractice which fortunately are rare. It can and does weed out the cases of alleged malpractice due to misunderstanding, personal quarrels and ill advised interference, and uncalled for advice from relatives and so-called friends.

Whenever such a case is settled through sensible, reasonable discussion and explanation of facts, and such adjustments as are deemed necessary, everyone is benefited. The patient is spared the anxiety and expense of an unsuccessful suit, and the doctor and entire medical profession are spared the unfavorable and unfair publicity which such actions always produce.

All of us, public and profession alike, owe the men on this committee a debt of gratitude for the unselfish service they are rendering without any remuneration except the satisfaction of a job well done.

Albino H. Heichel M.D.

"Spring Clinic"

TEACHING PROGRAMS ANNOUNCED

J. W. GALE, M. D.

The Council on Scientific Work, in cooperation with the State Board of Health, the Wisconsin Division of the American Cancer Society, W.A.T.A., the Wisconsin Heart Association, the Wisconsin Chapters of the National Foundation for Infantile Paralysis, the Wisconsin Academy of General Practice, and the two medical schools, announces the following medical teaching programs. Details of the program were planned by a coordinating committee on postgraduate education, with Joseph Gale, M.D., representing the Council on Scientific Work.

Circuit Teaching Program 1:

JANESVILLE ★ STEVENS POINT ★ APPLETON

HOSPITAL "WET CLINICS"

1. APRIL 15–16–17: 7:30–10:30 p.m.

April 15: Mercy Hospital, Janesville
April 16: St. Michael's Hospital, Stevens Point
April 17: St. Elizabeth's Hospital, Appleton

PROGRAM:

"Leukemia," Robert Schilling, M.D., assistant professor of medicine, University of Wisconsin Medical School

"The Problem of Essential Hypertension," Charles Crumpton, M.D., assistant professor of medicine, University of Wisconsin Medical School

FEE: $3.00. No special fee if registered for second "Wet Clinic" on April 29, 30, May 1, and "Spring Clinic", on May 13, 14, 15.

2. APRIL 29–30–MAY 1: 7:30–10:30 p.m.

April 29: Mercy Hospital, Janesville
April 30: St. Michael's Hospital, Stevens Point
May 1: St. Elizabeth's Hospital, Appleton

PROGRAM:

"Treatment of Head Injuries," Theodore C. Erickson, M.D., associate professor (in charge of neurosurgery), University of Wisconsin Medical School

"Surgical Lesions of the Esophagus," Forrester Raine, M.D., associate clinical professor of surgery, Marquette University School of Medicine

FEE: $3.00. No special fee if registered for both "Wet Clinics" and "Spring Clinic" on May 13, 14, 15.

3. MAY 13–14–15: "SPRING CLINIC": 2:00–9:00 p.m. (with dinner)

May 13: Monterey Hotel, Janesville
May 14: Stevens Point (Location to Be Announced)
May 15: Elks Club, Appleton

PROGRAM:

Moderator: G. C. Collentine, Jr., M.D., coordinator of postgraduate education, Marquette University School of Medicine

1:30 p.m.: REGISTRATION

2:00 p.m.: **Responsibilities of the Obstetrician in the Problem of Prematurity:** M. Edward Davis, M.D., Joseph Boliver DeLee professor of obstetrics and gynecology, Chicago Lying-in-Hospital, University of Chicago

2:30 p.m.: **Fractures of the Upper and Lower Extremities:** Walter Zeit, Ph.D., professor and director of the department of anatomy, Marquette University School of Medicine

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Banthine—a true anticholinergic drug with an adequate range of safety—is now made available to the medical profession in parenteral form, for use intravenously or intramuscularly in those conditions characterized by nausea and vomiting, when oral medication cannot be retained and when a prompt action is desirable.

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In Peptic Ulcer—the value of the oral form of Banthine is now well established. However, edema in the ulcer area may indicate parenteral Banthine until the healing processes have reduced the edema.

In Pancreatitis—it has been found that parenteral Banthine relieves pain, effects a fall in blood amylase and produces a general improvement in the patient's condition.

In Visceral Spasm—it inhibits motility of the gastrointestinal and urinary tracts.

Parenteral BANTHĪNE is supplied in serum-type ampuls containing 50 mg. of Banthine powder. Adult dosage is generally the same as with Banthine tablets.

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3:00 p.m.: **Trends in Therapy of Extremity Fractures:** Bruce Brewer, M.D., clinical instructor in orthopedic surgery, Marquette University School of Medicine
3:30 p.m.: **Advances in the Treatment of Tuberculosis:** J. W. Towey, M.D., superintendent and medical director, Pinecrest Sanatorium, Powers, Michigan
4:00 p.m.: 15 Minute Recess
4:15 p.m.: **Limp: A Danger Signal:** Doctor Brewer
4:45 p.m.: **Differential Diagnosis of Chest Diseases:** Doctor Towey
6:00 p.m.: DINNER
7:30 p.m.: **The Perineum:** Doctor Zeit
8:00 p.m.: **Indications and Contraindications for Induction in Labor:** Doctor Davis
8:30 p.m.: Questions of all Speakers

Note: In Stevens Point dinner speakers will be Doctor Brewer and Doctor Towey.

FEE: $6.00 for "Spring Clinic" only. $10 for spring clinic and two hospital conferences.

Circuit Teaching Program 2:

RACINE ★ MARINETTE–MENOMINEE, MICH. ★ SHEBOYGAN

HOSPITAL "WET CLINICS"

1. APRIL 22–23–24: 7:30–10:30 p.m.

April 22: St. Mary's Hospital, Racine
April 23: St. Joseph's Hospital, Menominee, Mich.
April 24: Memorial Hospital, Sheboygan

PROGRAM:

"Proper Handling of the Premature Infant," John Gonce, Jr., M.D., professor of pediatrics, University of Wisconsin Medical School

"Ankle Fractures," Herman W. Wirka, M.D., associate professor of orthopedic surgery, University of Wisconsin Medical School

FEE: $3.00. No special fee if registered for both "Wet Clinics" and for "Spring Clinic" on May 20, 21, and 22.

2. MAY 6–7–8: 7:30–10:30 p.m.

May 6: St. Mary's Hospital, Racine
May 7: St. Joseph's Hospital, Menominee, Mich.
May 8: St. Nicholas Hospital, Sheboygan

PROGRAM:

"Surgical Diseases of the Colon and Rectum," Kenneth Lemmer, M.D., associate professor of surgery, University of Wisconsin Medical School

"Treatment in Diabetes," Bruno J. Peters, M.D., assistant clinical professor of medicine, Marquette University School of Medicine

FEE: $3.00. No special fee if registered for both "Wet Clinics" and "Spring Clinic" on May 20, 21, and 22.

3. MAY 20–21–22: "SPRING CLINICS": 2:00–9:00 p.m. (with dinner)

May 20: Racine Country Club, Racine
May 21: Riverview Country Club, Menominee, Mich.
May 22: Foeste Hotel, Sheboygan

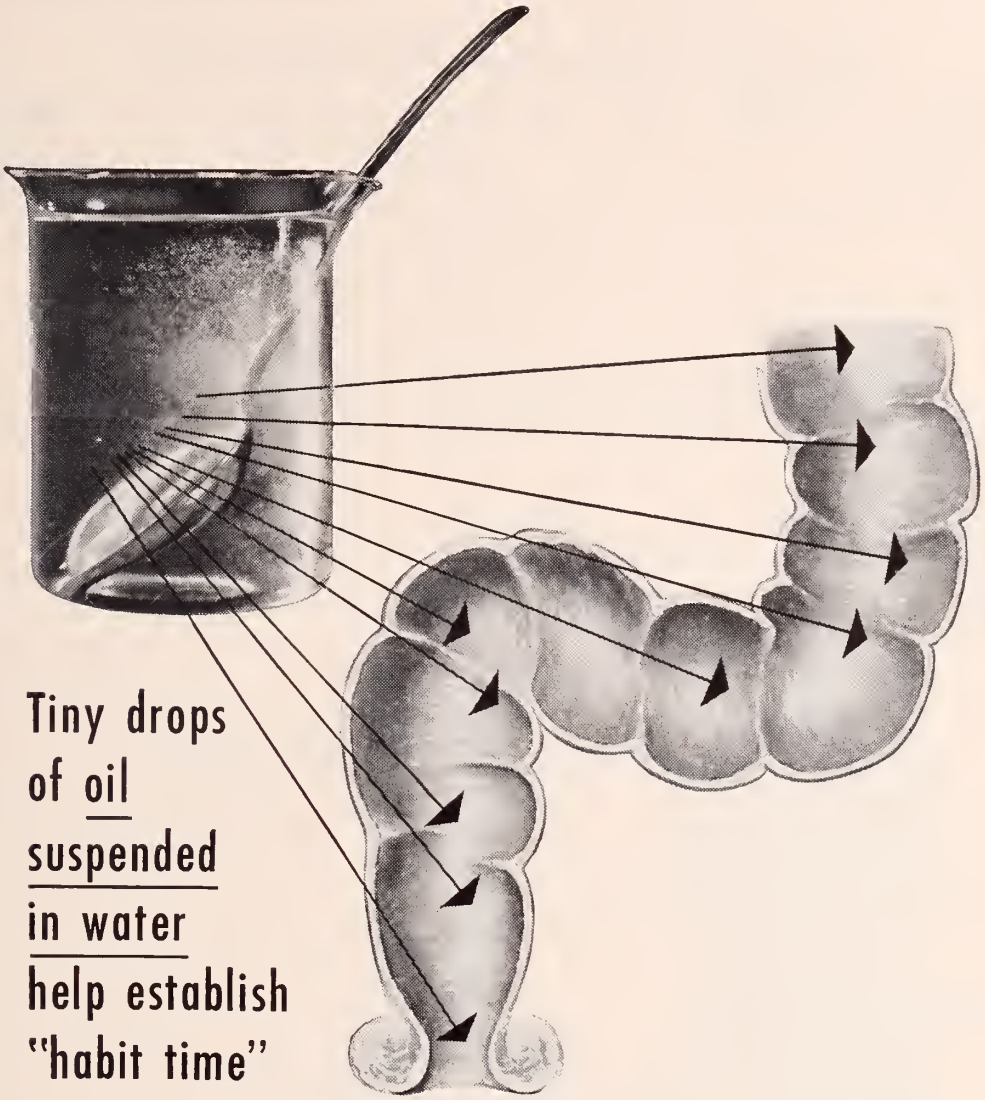
Moderator: E. H. Jorris, M.D., assistant state health officer, Madison

PROGRAM:

1:30 p.m.: REGISTRATION
2:00 p.m.: **Pharmacologic Action of Cardiac Drugs:** O. Sidney Orth, M.D., professor of pharmacology and anesthesiology, University of Wisconsin Medical School
2:30 p.m.: **Therapeutic Use of Cardiac Drugs:** Ovid O. Meyer, M.D., professor of medicine, University of Wisconsin Medical School
3:00 p.m.: **The Diagnosis and Treatment of Hyperthyroidism:** Edmund B. Flink, M.D., associate professor of internal medicine, University of Minnesota Medical School, Minneapolis
3:30 p.m.: **Common Gynecologic Surgical Procedures:** Walter J. Reich, M.D., professor of gynecology, Cook County Graduate School, Chicago
4:00 p.m.: 15 Minute Recess
4:15 p.m.: **Current Drug Additions of Clinical Promise:** Doctor Orth
4:45 p.m.: **The Treatment of the Alkalosis of Vomiting and Other Disturbances of Fluid and Electrolyte Balance:** Doctor Flink
6:00 p.m.: DINNER
7:30 p.m.: **The Anemias:** Doctor Meyer
8:00 p.m.: **Management of Common Gynecologic Office Problems:** Doctor Reich
8:30 p.m.: Questions of all Speakers

Note: In Menominee the dinner speakers will be Doctors Orth and Flink.

FEE: $6.00 for "Spring Clinic" only. $10 for spring clinic and two hospital conferences.



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Circuit Teaching Program 3:

RICHLAND CENTER ★ CHIPPEWA FALLS ★ MERRILL

APRIL 23	APRIL 24	APRIL 25
VFW Post Club House	Northern Hotel	Badger Hotel

Moderator: Robert C. Parkin, M.D., director of postgraduate education, University of Wisconsin Medical School

PROGRAM:

1:30 p.m.: REGISTRATION
2:00 p.m.: **Abnormalities in Growth:** E. S. Gordon, M.D., associate professor of medicine, University of Wisconsin Medical School
2:30 p.m.: **Fractures in Children:** Walter Blount, M.D., Children's Hospital, Milwaukee
3:15 p.m.: **Responsibilities of the Obstetrician in the Problem of Prematurity:** William C. Keettel, associate professor of obstetrics and gynecology, University of Iowa College of Medicine, Iowa City
3:45 p.m.: 15 Minute Recess
4:00 p.m.: **Recent Developments in the Treatment of Heart Disease:** Horace M. Korns, M.D., Iowa City
4:30 p.m.: **Common Disorders of Growing Bone:** Doctor Blount
4:50 p.m.: **Indications and Contraindications for Induction in Labor:** Doctor Keettel, M.D.
6:00 p.m.: DINNER
7:30 p.m.: **Differential Diagnosis of Pain in the Chest:** Doctor Korns
8:00 p.m.: **Danger Signals in the Use of ACTH and Cortisone:** Doctor Gordon
8:30 p.m.: Questions of all Speakers

Note: In Chippewa Falls Doctors Blount and Keettel will be dinner speakers.

FEE: $6.00, including dinner.

Credit for Academy Members

All of the above courses are certified for formal teaching credit for members of the Wisconsin Academy of General Practice.

3 Hours for each of the Hospital "Wet Clinics"
5 Hours for each of the "Spring Clinics"

Registration:

CIRCUIT PROGRAM 1: JANESVILLE, STEVENS POINT, APPLETON

Entire Series: $10.00
Hospital "Wet Clinics" Only: $3.00 each
Spring Clinic Only: $6.00 (includes dinner)

Where you will attend: Janesville _____, Stevens Point _____, Appleton _____

(MAKE YOUR CHECK PAYABLE TO THE STATE MEDICAL SOCIETY OF WISCONSIN)

Let Us Know What Meetings Your Reservation Covers

CIRCUIT PROGRAM 2: RACINE, MARINETTE–MENOMINEE, MICH., SHEBOYGAN

Entire Series: $10.00
Hospital "Wet Clinics" Only: $3.00 each
Spring Clinic Only: $6.00 (includes dinner)

Where you will attend: Racine _____, Marinette–Menominee, Mich. _____, Sheboygan _____

(MAKE YOUR CHECK PAYABLE TO THE STATE MEDICAL SOCIETY OF WISCONSIN)

Let Us Know What Meetings Your Reservation Covers

CIRCUIT PROGRAM 3: RICHLAND CENTER, CHIPPEWA FALLS, MERRILL

$6.00 (includes dinner). Check where you will attend:

April 22: Richland Center _____ April 23: Chippewa Falls _____

April 24: Merrill _____

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Neurologists and Neurosurgeons
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It readily passes into the cerebrospinal fluid, the presence of meningitis making little difference in its concentration.

Measurable serum levels are maintained for as long as 12 hours after oral administration, oral doses of 5 to 10 mg. per kilo at 6-hour intervals being adequate for this purpose.

Aureomycin has been shown to be highly effective against those bacterial invaders commonly encountered in central nervous system infections.

Aureomycin has been reported to be effective against susceptible organisms in: Brain Abscess • Cranial Trauma Infection • Encephalitis • Meningitis

Throughout the world,
as in the United States,
aureomycin is recognized as a
broad spectrum antibiotic
of established effectiveness.

Capsules: 50 mg.—Bottles of 25 and 100; 250 mg.—Bottles of 16 and 100. *Ophthalmic:* Vials of 25 mg. with dropper; solution prepared by adding 5 cc. of distilled water.

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Society Proceedings

Barron–Washburn–Sawyer–Burnett

Meeting on December 11, the members of the Barron–Washburn–Sawyer–Burnett County Medical Society held their annual election of officers. Serving as president is *Dr. Robert E. Lund*, Cumberland, and officers who will work with him are *Drs. Martin H. Sahs*, Spooner, vice-president; and *Clive J. Strang*, Barron, secretary-treasurer.

Brown–Kewaunee–Door

A dinner was held prior to the December 13 meeting of the Brown–Kewaunee–Door County Medical Society. The members, meeting at the Beaumont Hotel in Green Bay, elected *Drs. J. L. Ford*, Green Bay, president; *S. M. Mokrohijisky*, Green Bay, president-elect; *G. B. Merline*, De Pere, vice-president; *G. M. Shinners*, Green Bay, secretary-treasurer; *R. W. Kispert*, Green Bay, censor for 1952 to 1954; *J. A. Killins*, Green Bay, and *J. W. Nellen*, Green Bay, delegates; and *R. M. Waldkirch*, De Pere, and *P. F. Dockry*, Green Bay, alternates.

Calumet

Members of the Calumet County Medical Society met at the Old Mill in Hayton on November 8 for their annual election of officers. *Dr. F. P. Larme* of New Holstein was reelected president and *Dr. L. W. Keller* of Brillion was reelected secretary-treasurer.

Clark

A business meeting of the Clark County Medical Society was held in the Citizens State Bank at Loyal on January 31. Special guests were the director of the Clark County Welfare Department and members of the welfare committee of the Clark County Board of Supervisors. The visitors led a discussion on the new methods of billing for medical care of recipients of old age assistance.

Crawford

The new officers of the Crawford County Medical Society are *Drs. O. E. Satter*, president, and *H. L. Shapiro*, secretary-treasurer, both from Prairie du Chien. The Society also met on January 17 at Kraber's Nite Club for dinner with the Woman's Auxiliary.

Fond du Lac

Dr. N. L. Low of Racine was the featured speaker at the January 31 meeting of the Fond du Lac County Medical Society. Meeting with the Society at the Hotel Retlaw in Fond du Lac, Doctor Low chose "Convulsions in Childhood" as his subject.

Eau Claire–Dunn–Pepin

A recent meeting of the Eau Claire–Dunn–Pepin County Medical Society resulted in the election of the following officers for 1952:

President—*Dr. W. G. Cameron*, Eau Claire
Vice-President—*Dr. Robert Strand*, Eau Claire
Secretary-Treasurer—*Dr. H. E. Sorenson*, Eau Claire
Delegate—*Dr. Oscar Moland*, Augusta
Alternate Delegate—*Dr. R. J. Bryant*, Durand.

Grant

The Grant County Medical Society met November 29 for a combined scientific and business meeting. *Dr. Ovid Meyers*, Madison, addressed the Society on "Recent Advances in Treatment." During the business meeting, the following officers were elected for 1952: president, *Dr. N. G. Rasmussen*, Montfort; vice-president, *Dr. James L. Moffett*, Platteville; and secretary-treasurer, *Dr. H. W. Carey*, Lancaster.

Jefferson

Dr. E. A. Miller, Watertown, was elected president for 1952 of the Jefferson County Medical Society at a meeting held at Radtke's Tea Room in Jefferson. Other officers elected were *Drs. O. H. Hanson*, Fort Atkinson, vice-president; *E. J. Netzow*, Lake Mills, secretary-treasurer; *C. J. Garding*, Jefferson, delegate; and *F. A. Gruesen*, Fort Atkinson, alternate delegate.

Kenosha

Meeting on December 13 at the Elks Club in Kenosha, the Kenosha County Medical Society elected the following officers for the year: president, *Dr. Harry L. Schwartz;* president-elect, *Dr. Gilbert J. Schwartz;* secretary, *Dr. Helen A. Binnie;* delegate, *Dr. David N. Goldstein;* and alternate delegate, *Dr. Leif H. Lokvam.* All of the officers are from Kenosha. The scientific address for the meeting was given by Dr. Julius Richmond, professor of pediatrics at the University of Illinois School of Medicine, who presented a paper on "Surgical Emergencies in Newborn Infants."

The Society also met on January 3, at which time *Dr. Joseph Mufson*, clinical instructor in neurosurgery at the Marquette University School of Medicine, spoke on "The Diagnosis of Head Injuries." During the business session plans for local participation in a student essay contest sponsored by the Association of American Physicians and Surgeons were formulated. The contest will be open to students of the seventh through twelfth grades on the subject "Why the Private Practice of Medicine Furnishes This Country with the Finest Medical Care."

All Children Can Benefit from *this* Protective Hot Drink at Breakfast

In its widely distributed leaflet No. 268, "Eat a Good Breakfast," the U. S. Dept. of Agriculture states: "Summer or winter, there's something hot, as a rule, in a good breakfast.... Something hot is cheering and tones up the whole digestive route."

The problem of encouraging children to eat an adequately protective breakfast finds easier solution when Ovaltine in hot milk is recommended as a breakfast beverage. Many children clamor for a hot drink at the morning meal, and hot Ovaltine is the right kind of drink to recommend.

A cup of hot Ovaltine makes an excellent contribution of virtually all essential nutrients, adding substantially to the nutritional start for the day. It also serves in a gustatory capacity by enhancing the appeal of breakfast and making other foods more inviting.

The nutrient contribution made by a cup of Ovaltine is apparent from the table below. Note the wealth of essentials added to the nutritional intake by making the simple recommendation of adding a cup of hot Ovaltine to the child's breakfast.

THE WANDER COMPANY, 360 N. MICHIGAN AVE., CHICAGO 1, ILLINOIS

Ovaltine

Here are the nutrients that a cupful of hot Ovaltine, made of ½ oz. of Ovaltine and 8 fl. oz. of whole milk,* provides:

PROTEIN	10.5 Gm.	IRON	4 mg.	NIACIN	2.3 mg.
FAT	10.5 Gm.	COPPER	0.2 mg.	VITAMIN C	10 mg.
CARBOHYDRATE	22 Gm.	VITAMIN A	1000 I.U.	VITAMIN D	140 I.U.
CALCIUM	370 mg.	VITAMIN B_1	0.39 mg.	CALORIES	225
PHOSPHORUS	315 mg.	RIBOFLAVIN	0.7 mg.		

*Based on average reported values for milk.

Lafayette

The Lafayette County Medical Society held a meeting on December 29 for the purpose of electing officers for the year. The results were as follows:

President—*Dr. D. J. Garland*, Shullsburg
Vice-President—*Dr. L. L. Thompson*, Argyle
Secretary-Treasurer—*Dr. N. A. McGreane*, Darlington
Delegate—*Dr. L. J. Unterholzner*, Blanchardville
Alternate Delegate—*Doctor McGreane*

Langlade

Dr. D. W. Daily, Elcho, will head the Langlade County Medical Society during 1952, as the result of an election held at the December meeting of the organization. Other members named to office were *Drs. F. H. Garbisch*, Antigo, secretary-treasurer, and delegate; and *C. E. Zellmer*, Antigo, alternate delegate.

Lincoln

The Lincoln County Medical Society met in Merrill at the Badger Hotel on October 31 to elect new officers. Those chosen were *Drs. L. J. Bayer*, Merrill, president; *W. C. McCormick*, Tomahawk, vice-president; *J. D. Millenbah*, Merrill, secretary-treasurer; *R. G. Baker*, Tomahawk, delegate; *K. A. Morris*, Merrill, alternate delegate; *E. O. Ravn*, Merrill, auditing committee; and *K. A. Morris*, Merrill, and Doctor Ravn, advisory committee.

Marathon

At a recent meeting of the Marathon County Medical Society, the members elected the following slate of officers:

President—*Dr. D. M. Green*
President-Elect—*Dr. H. W. Christensen*
Secretary-Treasurer—*Dr. G. R. Hammes*
Delegate—*Dr. H. R. Fehland*
Alternate Delegate—*Dr. E. P. Ludwig*

All of the officers are from Wausau.

Oneida–Vilas

Dr. G. R. Thuerer, Rhinelander, was named president of the Oneida–Vilas County Medical Society at a recent meeting. *Dr. I. E. Schiek, Sr.*, Rhinelander, was chosen vice-president, and *Dr. Marvin Wright*, Rhinelander, secretary-treasurer and delegate.

Outagamie

Members of the Outagamie County Medical Society and their wives attended the society's annual Christmas dinner party on December 20 at the Elks Club in Appleton. The new officers were introduced at the dinner. They are *Drs. L. B. McBain*, president; *W. S. Giffin*, vice-president; and *W. A. Adrians*, secretary, all from Appleton.

Polk

Dr. Ben Sommers, St. Paul, Minn., and Miss Elizabeth Winperry, Polk County public health nurse were the guest speakers at the November 15 meeting of the Polk County Medical Society which was held at Paradise Lodge in Balsam Lake. Doctor Sommers spoke on "Clinical Aspects of Coronary Disease" and Miss Winperry chose "Nurses of Polk County in Civil Defense" as her topic. New officers for the year were chosen, and they are *Drs. W. A. Fischer*, Frederic, president; *H. A. Dasler*, Amery, president-elect; and *G. B. Noyes*, Centuria, secretary-treasurer. The society had a social meeting with the Woman's Auxiliary on December 13. *Dr.* and Mrs. *L. O. Simenstad* were hosts for the party.

Portage

The Portage County Medical Society met in December to hear a talk by Dr. Robert Schilling, Madison. His subject was the lukemias. During the business session new officers were named as follows: *Drs. M. G. Rice*, president; *V. A. Benn*, Rosholt, vice-president; *H. A. Anderson*, secretary-treasurer; and *J. A. Litzow*, chairman, *W. A. Gramowski*, and *F. C. Iber*, board of censors. All the officers are from Stevens Point unless otherwise stated.

Racine

Dr. J. M. Albino has been installed as the 1952 president of the Racine County Medical Society. Others installed at recent ceremonies were *Drs. K. W. Covell*, president-elect, *G. L. Rothenmaier*, vice-president, and *J. G. Jamieson*, secretary-treasurer. All of the officers are from Racine.

Trempealeau–Jackson–Buffalo

Meeting at St. Joseph's Hospital in Arcadia on January 17, the Trempealeau–Jackson–Buffalo County Medical Society heard an address by *Dr. S. W. Simonson*, Whitehall. His subject was "The Value of the Electrocardiogram As To the Diagnosis and Prognosis of Heart Diseases." *Dr. F. T. Weber* of Arcadia was chosen to head the society for the year. Other officers elected to serve with him are *Drs. O. M. Schneider*, Blair, president-elect; *E. P. Rohde*, Galesville, secretary-treasurer; *C. O. Rogne*, Ettrick, delegate; and *B. C. Dockendorff*, Arcadia, alternate delegate.

Washington–Ozaukee

The Washington–Ozaukee County Medical Society met at the hotel in Kewaskum on October 29. At that time the following officers were elected:

President—*Dr. P. B. Blanchard*, Cedarburg
Vice-President—*Dr. R. H. Driessel*, West Bend
Secretary-Treasurer—*Dr. K. F. Pelant*, Grafton
Delegate—*Dr. A. H. Barr*, Port Washington
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Walworth

Two University of Wisconsin Medical School professors, *Dr. E. R. Schmidt*, professor of surgery, and *Dr. E. S. Gordon*, associate professor of medicine, addressed the Walworth County Medical Society. Meeting with the society at the Walworth County Hospital on December 11, the two physicians chose "The Medical and Surgical Aspects of Geriatrics" as their subject. At this meeting *Dr. R. S. Galgano*, Delavan, was chosen new president of the Society. Others chosen to assist him were *Drs. Laird McNeel*, Genoa City, vice-president; *K. C. Bill*, Elkhorn, secretary-treasurer; *E. D. Sorenson*, Elkhorn, delegate; and *H. J. Kenney*, Delavan, alternate delegate.

Winnebago

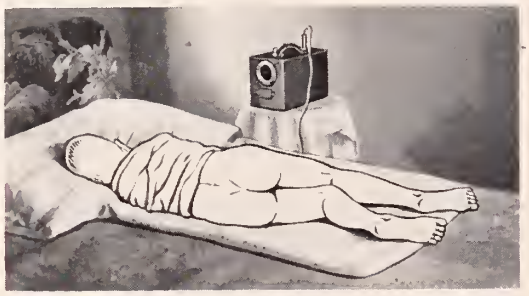
The regular meeting of the Winnebago County Medical Society was held at the Poinsetta Tea Room, Neenah, on December 6. *Dr. W. E. Clark*, Oshkosh, was elected president. Those who will serve with him are *Drs. J. R. Nebel*, Menasha, vice-president; and *Benjamin S. Greenwood*, Oshkosh, secretary-treasurer. The featured speaker for the evening was *Dr. M. G. Peterman*, Milwaukee, who chose as his subject "Ideopathic Epilepsy."

Ninth Councilor District

The physicians of the Ninth Councilor District met at St. Joseph's Hospital in Marshfield on November 15. *Dr. K. H. Doege*, Marshfield, served as moderator during the symposium. The guest speaker for the occasion was Dr. Forest H. Adams, assistant professor of pediatrics at the University of Minnesota Medical School, who spoke on "Experiences with ACTH and Cortisone in Thermal Burns of Infants." The following Marshfield physicians also presented papers: "Infant Methemoglobinemia, a Diagnostic Problem," by *Dr. J. S. Vedder;* "Tracheo–Esophageal Fistula, Recent Advances in Surgical Repair," by Dr. C. L. Holmes; "Infantile Eczema—Tips on Management," *Dr. Stephan Epstein;* "Bowel Resection of an Infant—Report of a Case," by *Dr. C. A. Vedder;* and "The Diagnosis of Urinary Tract Pathology in Infants and Children," by *Dr. N. J. Helland.*

National Gastroenterological Association Wisconsin Chapter

At a recent meeting the Wisconsin Chapter of the National Gastroenterological Association elected officers for 1952. *Dr. M. W. Shutkin* will head the organization as president. Elected to serve with Doctor Shutkin were *Dr. Joseph Shaiken*, vice-president, and *Dr. M. E. Gabor*, secretary-treasurer. All of the officers are from Milwaukee.



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News Items and Personals

Dr. H. H. Christofferson Addresses Group

Dr. H. H. Christofferson, Colby, immediate past president of the Society, addressed the Marshfield Rotary Club on November 26. Speaking at the Hotel Charles in Marshfield, Doctor Christofferson's topic was medical progress during the past 50 years and the efforts of the medical profession in Wisconsin to keep abreast of its responsibilities.

"Doctor Lundmark Day"

Wearing yellow tags saying "I am a Lundmark baby," more than 200 persons gathered in Ladysmith to honor *Dr. Lambert M. Lundmark* for his 47 years of service to that city and the surrounding area. The plans for the celebration were organized by the Ladysmith Junior Chamber of Commerce with the cooperation of the St. Mary's Hospital Auxiliary. The Auxiliary served the testimonial dinner on December 4 in honor of the doctor and a reception for friends followed the banquet. Highlight of the evening was the presentation of a purse which had been collected for the doctor. *Dr. M. L. Whalen* of Bruce presided as master of ceremonies.

Born on Bornholm Island in the Baltic Sea, Doctor Lundmark's mother brought her son to this country when he was five years old. He received his medical degree from the University of Minnesota Medical School in 1904 and established his practice in Ladysmith following graduation.

Dr. W. L. McLane Establishes Practice

Dr. William L. McLane established his practice in Gilman on October 15. A veteran of World War II, when he served in the coast guard, Doctor McLane practiced in Wilmington, Delaware before moving to Gilman. The doctor is replacing Dr. A. L. Cramp, former Gilman physician who moved to Momence, Illinois last January.

Dr. G. L. Bellis Retires

Dr. G. L. Bellis, who has been medical director of the Sunny View Sanatorium, Oshkosh, for the past nine years, retired from that post on October 31. He will make his home at Dundie, Florida. *Dr. V. G. Guenther* of Oshkosh was appointed to the vacant post on a part-time basis.

Dr. John Grindrod Joins Dr. John Bell

Dr. John Grindrod recently began his practice in Peshtigo as assistant to *Dr. J. M. Bell*. A graduate of the University of Wisconsin Medical School, Doctor Grindrod served his internship at the Harbor View Hospital in Seattle, Washington, prior to moving to Peshtigo.

Doctor McAfee Speaks Before Eau Claire Group

Dr. George McAfee, who recently established his practice in dermatology in Eau Claire, was the guest speaker at a November meeting of the Eau Claire Exchange Club. Doctor McAfee explained the manner in which one becomes a medical specialist and also spoke on phases of his own specialty. In addition, he praised the city water plant and the sewage disposal systems in Eau Claire.

Medical Examiners Elect Officers

Dr. J. W. Prentice of Ashland was recently elected president of the State Board of Medical Examiners. He succeeds *Dr. A. F. Rufflo* of Kenosha in that position. The group reelected *Dr. A. G. Koehler* of Oshkosh for the post of secretary.

Dr. M. T. O'Meara Certified by Specialty Group

Dr. Mark T. O'Meara was recently certified as a diplomate of the American Board of Surgery. The doctor who is affiliated with the Grandview Clinic in La Crosse, graduated from Marquette University School of Medicine and took his surgical residency at Milwaukee County Hospital.

Dr. J. G. Heisel Becomes Associate of Dr. J. H. Weisberg

Dr. John G. Heisel recently became associated with *Dr. J. H. Weisberg* in Superior in the practice of medicine and surgery. Doctor Heisel who is a graduate of the University of Marquette School of Medicine, served his internship at St. Luke's Hospital in Duluth. He served in the U. S. Navy as a lieutenant (J. G.) during World War II.

New Richmond Physician Honored

Dr. R. R. Davis of New Richmond was recently admitted as a Fellow of the American College of Surgeons at San Francisco, California. The doctor and his wife flew to California for the meeting. Prior to practicing at Shell Lake, Doctor Davis practiced at River Falls and had also been on the staff of Wisconsin General Hospital, Madison.

Thorp Doctor Addresses Hospital Staff

Dr. Eleanora Jorgenson, Thorp physician, spoke at the December meeting of the Victory Memorial Hospital, Stanley, medical staff. She presented a discussion of industrial poisons as found in rural communities.

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—Editor's Note

THIRD DISTRICT NEWS

Madison Physician Certified by Ophthalmic Examiners

Dr. John V. Berger, Jr., who is on the staff of the Davis, Neff, and Duehr Clinic, Madison, recently received the certificate of the American Board of Ophthalmic Examiners. Doctor Berger is a 1938 graduate of the University of Wisconsin Medical School and served his internship and residency at Research Hospital, Kansas City, Mo.

Jackson Clinic Has Three New Staff Members

Three physicians have recently joined the staffs of the Jackson Clinic and the Methodist Hospital, Madison. Doctor Newell G. Ingle, who has just completed a four year residency in surgery at Cleveland City Hospital, Cleveland, Ohio, will be associated with *Dr. Arnold S. Jackson* in surgery. After graduating from the University of Iowa Medical School in 1944, Doctor Ingle interned at Cleveland City Hospital and then served in the U. S. Army.

Dr. John J. Mueller, who has been in private practice in La Crosse until recently, will be an associate of *Dr. George Ewell* in the department of urology. Doctor Mueller graduated from the University of Iowa Medical School in 1936, interned at St. Francis Hospital in Evanston, Illinois, and served his urology residency at Presbyterian Hospital in Philadelphia.

Dr. Thomas Rutter, a 1945 graduate of the Harvard Medical School, will be associated with Doctor Jackson in surgery. Doctor Rutter recently completed a one year residency in surgery at the Memorial Cancer Hospital, New York City. He had also served four years on the surgical service at Massachusetts General Hospital, Boston and a one year residency at Jefferson Davis Hospital, Houston, Texas.

Doctor Harmon Becomes Associate of Madison Physician

Dr. Doralea R. Harmon, a graduate of the University of Wisconsin Medical School, has joined *Dr. Royden F. Collins* as an associate in general practice. Doctor Harmon interned at Madison General Hospital.

SOCIETY PROCEEDINGS

Columbia–Marquette–Adams

The wives of the members of the Columbia–Marquette–Adams County Medical Society were special guests at the dinner on December 11, held at the Portage Hotel in Portage. The annual election of officers was held and the president for 1952 is *Dr. R. F. Inman*, Montello; the vice-president, *Dr. John Harkins*, Portage; and the secretary, *Dr. E. G. Nafziger*, Oxford.

Sauk

Dr. John E. Gonce, Jr., professor of pediatrics of the University of Wisconsin Medical School was the guest speaker at the December 11 meeting of the Sauk County Medical Society, which was held in Baraboo at the Warren Hotel. Doctor Gonce addressed the members on the subject of "Feeding Problems in Infancy and Childhood." During the business session the annual election of officers was held and resulted in the following being elected: *Ernest V. Stadel*, Reedsburg, president; *C. R. Pearson*, Baraboo, vice-president; *John J. Rouse*, Reedsburg, secretary-treasurer; *John F. Moon*, Baraboo, Delegate; and Doctor Rouse alternate delegate. *Drs. Harold A. Bachhuber*, Sauk City; *John A. Booher*, La Valle; and *Fred E. Tryon*, Baraboo were elected to the Board of Censors.

American Academy of General Practice Madison Chapter

Meeting at the Park Hotel on January 22, the Madison area chapter of the American Academy of General Practice elected *Dr. John A. Grab*, Madison, president for 1952. Other officers to serve with Doctor Grab are *Dr. R. F. Collins*, president-elect; *T. J. Nereim*, secretary; and *Louis Fauerbach*, treasurer. *Drs. R. H. Ludden* and *Wendell H. Marsden* were named delegates to the state convention and *Drs. L. V. Sprague*, and *M. T. Morrison*, Mt. Horeb, were elected alternates. Unless otherwise stated, all officers are from Madison.

In addition to selecting officers, chapter members discussed plans and named committees for the Academy of General Practice state convention which will be held in Madison on November 11–12.

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Surgery of Colon & Rectum, One Week, starting March 3, April 7.
Gallbladder Surgery, Ten Hours, starting April 21.
Basic Principles in General Surgery, Two Weeks, starting March 31.
Breast & Thyroid Surgery, One Week, starting June 23.
Esophageal Surgery, One Week, Starting June 23.
Thoracic Surgery, One Week, starting June 2.
Fractures & Traumatic Surgery, Two Weeks, starting February 4.
GYNECOLOGY—Intensive Course, Two Weeks, starting February 18, March 17.
Vaginal Approach to Pelvic Surgery, One Week, starting March 3, March 31.
OBSTETRICS—Intensive Course, Two Weeks, starting March 3, March 31.
MEDICINE—Intensive General Course, Two Weeks, starting May 5.
Electrocardiography & Heart Disease, Two Weeks, starting March 17.
Gastroenterology, Two Weeks, starting May 19.
Hematology. One Week, starting June 16.
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Medical School Society of the University of Wisconsin

Dr. Harold G. Wolff of the New York Hospital, New York City, addressed the January 28 meeting of the Medical School Society of the University of Wisconsin. Speaking at the Auditorium, Service Memorial Institute, Doctor Wolff chose as his subject the "Headache Mechanisms."

Third Councilor District

Dr. H. Kent Tenney presided during the scientific session of the December 12 meeting of the Third Councilor District which was held at the Park Hotel in Madison. The first speaker was Dr. Robert Schilling, assistant professor of medicine at the University of Wisconsin Medical School, who spoke on "Leukemia". He was followed by *Dr. M. G. Peterman,* Milwaukee, speaking on "Epilepsy As Related to Pediatric Practice," and by *Dr. Henry M. Suckle,* Madison, whose topic was "Epilepsy From the Viewpoint of Adult Patients." *Dr. H. E. Kasten,* Beloit, presided at the dinner, and Mr. C. H. Crownhart opened the evening program with a talk on "Where We Stand With Our Insurance Program." *Dr. O. O. Meyer,* professor of medicine, University of Wisconsin Medical School, closed the program with a paper on "Arthritis."

TWELFTH DISTRICT NEWS

Marquette Receives Cancer Grant

The Milwaukee Division of the American Cancer Society has awarded a $25,000 grant to Marquette University School of Medicine to be used for research on leukemia. *Dr. Anthony V. Pisciotta,* a graduate of the Marquette Medical School who is at present working in Boston as assistant to Dr. William Damashek, has been chosen to head the project. He will devote full time to the program beginning July 1, working directly with leukemia patients at Milwaukee County Hospital.

Dr. J. J. Smith Accepts Post at Marquette

Dr. Percy F. Swindle, professor and director of the department of physiology at Marquette University School of Medicine since 1922, has announced that he is retiring from his administrative duties to devote more time to research. He will continue as an active member of the department. Dr. James J. Smith, former dean of the Medical School at Loyola University, Chicago, and presently chief of the education division of the department of medicine and surgery at the Veterans Administration Central Office, Washington, D. C., has been named to succeed Doctor Swindle. He will join the medical faculty in March, taking charge of the department July 1.

Doctor Peterman Addresses Out-of-State Groups

M. G. PETERMAN

Dr. M. G. Peterman, Milwaukee, addressed the Southeast Texas Pediatric Society in Beaumont, Texas, on November 28. His subject was "The Treatment of Epilepsy in Children." Doctor Peterman has also recently addressed the Alabama Pediatrics Society, the Columbia, South Carolina, Medical Society, and the staff of the Veterans Hospital in Columbia.

Wisconsin Physicians Attend Meeting

Drs. J. B. Hitz and *C. H. Kalb* of Milwaukee presented papers at the Pan-American Ophthalmological Association Congress which opened January 6 in Mexico City. Among the other Wisconsin physicians who attended the meeting were Drs. *M. J. Bach, S. G. Higgins, R. P. Sproule,* and *H. G. Schmidt,* all of Milwaukee; *William Meier,* Sheboygan; *William Bennett,* Racine; and *Aubrey Pember,* Janesville.

Milwaukee Physician Addresses Cudahy Group

Dr. C. J. Buscaglia, Milwaukee, addressed the members of the St. Frederick's Home and School Association, Cudahy, on December 12, in the school hall. His topic "What Psychiatry Means," covered the attitude of parents and how it affects children.

SOCIETY PROCEEDINGS

Milwaukee

The Medical Society of Milwaukee County held its annual dinner meeting on December 13 at the Milwaukee Athletic Club. The guest speaker for the occasion was Donald J. Cowling, president emeritus of Carleton College, Northfield, Minn., whose subject was, "What Did Our Forefathers Try to Accomplish?" *Dr. N. J. Wegmann* was inaugurated as president for 1952 and other officers elected were *Drs. Robert S. Irwin,* president-elect; *William T. Casper,* secretary; and *Paul F. Hausmann,* treasurer.

Meeting January 10 at the Milwaukee Athletic Club, the Society heard an address by Dr. John H. Garlock, professor of surgery at Columbia University Medical School. His subject was "The Surgical Treatment of Regional Enteritis." Other speakers were *Dr. John S. Hirschboeck,* dean of the Mar-

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quette University Medical School, who discussed the use of medical students in the civilian defense program; and *Dr. Joseph W. Rastetter*, director of the cancer diagnostic clinic, who described the clinic's work in 1951.

American Academy of General Practice Milwaukee Chapter

Dr. Donald C. Ausman took office as president of the Milwaukee Chapter of the American Academy of General Practice when the Academy met at the Astor Hotel on December 11. Other officers who will serve with Doctor Ausman are *Drs. John A. Enright*, president-elect; *Gabriel E. Ceci*, secretary; *Louis B. Uszler*, treasurer; *Howard M. Klopf* and *R. W. Garens*, delegates to the state academy.

Milwaukee Academy of Medicine

S. A. MORTON, M. D.

The members of the Milwaukee Academy of Medicine met at the University Club on December 18 to hear a talk by Dr. John W. Gofman, clinical instructor in medicine at the University of California Medical School, San Francisco. "Some Recent Concepts of the Pathogenesis and Management of Coronary Artery Disease" was the subject chosen by the guest.

At the annual dinner meeting held on January 15, the Academy installed *Dr. S. A. Morton* as president for 1952, and elected *Dr. Albert C. Schmidt* president-elect. Officers reelected were *Drs. A. A. Schaefer*, vice-president; *Joseph F. Kuzma*, secretary; *V. F. Lang*, treasurer; and *Arthur A. Holbrook*, librarian. Dr. Russell N. Woroboc was named winner of the Horace Manchester Brown essay contest. Second place winner was *Dr. Richard J. Mayer*.

Milwaukee Neuro-Psychiatric Society

The Milwaukee Neuro-Psychiatric Society met at the Shorewood Hospital Sanitarium on November 28 to hear a discussion by *Dr. Peter Bell*, supervisor of the Psychiatric Field Service, and by Mr. Russell G. Oswald, director of the Division of Corrections of the Department of Public Welfare. The gentlemen chose as their subject for the evening, "Psychiatric Practices in the Correctional and Penal Institutions of Wisconsin."

Meeting at the Hospital Annex, Veterans Administration Center, Wood, on January 16, the members of the Society toured the Hospital Annex and were served dinner in the Hospital dining room. Featured speaker of the evening was Dr. Harvey J. Tompkins, chief, psychiatry and neurology division of the Veterans Administration, Washington, D. C. Doctor Tompkins chose "The Twilight of the Specialized Hospital" as the subject of his address.

Milwaukee Oto-Ophthalmic Society

The Milwaukee Oto-Ophthalmic Society held its first meeting of the 1951–52 season on November 27 at Veterans Hospital, Wood. The combined oto-ophthalmology staff of that hospital presented the scientific program.

The staff of Milwaukee Children's Hospital gave the program when the Society met at the University Club on January 22. A social hour and dinner preceded the scientific session.

SOCIETY RECORDS

New Members

R. P. Still, 120½ Clark Street, Wausau.

C. J. O'Neill, 949 Lincoln Boulevard, Manitowoc.

J. M. Guthrie, 302 Cleveland Street, Brillion.

R. A. Knudson, Horicon.

R. H. Schoeneman, Butler.

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G. P. Nichols, Wisconsin State Sanatorium, Statesan.

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Changes in Address

Ballard Hayworth, Madison, to Tenth & Fillmore, Topeka, Kansas.

A. H. Lamal, Ashland, to Waterford City, North Dakota.

I. J. Sarfatty, Madison, to 3037 North Downer Avenue, Milwaukee.

J. F. Wepfer, Madison, to 808 West Ninth Street, Emporia, Kansas.

K. G. Kastl, Akron, Ohio, to 422 Bryn Maur Avenue, Bala Cynwyd, Pennsylvania.

T. A. Burns, Wood, to 208 East Wisconsin Avenue, Milwaukee.

E. S. Braden, Sturgeon Bay, to 2600 McDaniel Avenue, Evanston, Illinois.

L. L. Sanford, Viroqua, to Hillsboro.

J. C. H. Russell, Selfridge, Air Force Base, Michigan, to Surgeon 2473 AFRTC, General Mitchell Field, Milwaukee.

D. E. Hackbarth, New York, New York to 208 East Wisconsin Avenue, Milwaukee.

R. H. Wasserburger, Minocqua, to Veterans Administration Hospital, Madison.

W. F. Cryns, Briggsville, to 326 Alles Street, Des Plaines, Illinois.

R. R. Davis, Shell Lake, to 101 North Main Street, New Richmond.

S. B. Crepea, Texas, to Hq. & Hq. Sq., 3650 Medical Group, Sampson Air Force Base, Geneva, New York.

J. K. Quinlivan, Madison, to 240 Tuscarara Road, Buffalo 20, New York.

E. L. Baum, Naples, Florida, to 1603 South Layton Boulevard, Milwaukee.

A. A. Bullock, Jr., Wood, to 2012 East Edgewood Avenue, Milwaukee.

J. W. Frye, San Francisco, California, to 179 East Fairmount Avenue, Milwaukee. (Military service member, mailing address only.)

J. F. G. Gates, Wauwatosa, to 2874 North 87th Street, Milwaukee.

E. C. Grosskopf, Milwaukee, to 851 Oakland Avenue, Waukesha.

H. J. Kanin, Wood, to 5515 West Melvina Street, Milwaukee.

J. E. Koepsell, Milwaukee, to 606 North Hart Boulevard, Harvard, Illinois.

A. J. Krygier, Wood, to 425 East Wisconsin Avenue, Milwaukee.

R. B. Leitschuh, Wood, to 3577 South 16th Street, Milwaukee.

T. J. Litzow, Wood, to 216 West Wabash Avenue, Waukesha.

T. G. Malloy, Wood, to Veterans Administration, Little Rock, Arkansas.

W. K. McCreary, Wauwatosa, to 140 Medical Group, Buckley Field, Colorado.

J. R. O'Connell, Wood, to 1227 West Lincoln Avenue, Milwaukee.

E. N. Silber, Milwaukee, to Michael Reese Hospital, Chicago, Illinois.

J. H. Hardgrove, Eden, to Shawano.

W. R. McInnis, Antigo, to Marion.

B. H. Roisum, Oak Ridge, Tennessee, to % Medical Associates, 1200 Main Street, Dubuque, Iowa.

M. T. Sandeno, Wisconsin Dells, to 803 Seventh Street, Safford, Arizona.

S. G. Schwarz, Humbird, to Merrillan.

W. K. Hoffman, Milwaukee, to 3461 ASU, USAH, Camp Rucker, Alabama.

J. G. Frisch, Milwaukee, to 128th AC & W Squadron, Dow Field, Bangor, Maine.

S. T. Gettelman, Racine, to U. S. Army Hospital, Fort Riley, Kansas.

W. H. Lohr, 02096596, San Antonio, Texas, to Ninth Regiment Medical Company, APO 248, % Postmaster, San Francisco, California.

J. M. Bell, Peshtigo, to 1723½ Main Street, Marinette.

W. E. Braun, Iron Mountain, Michigan, to 2209–63rd Street, Kenosha.

W. F. Larrabee, Rhinelander, to 120 Eleventh Avenue, N. E., Rochester, Minnesota.

DEATHS

Dr. J. J. Eisenberg, a Milwaukee surgeon, died suddenly on November 11, at his home in that city. He was 61 years old.

Born in Russia on July 4, 1890, the doctor moved to the United States with his family when he was five years old. After graduating from the Marquette University pharmacy course in 1911, he received his medical degree from the George Washington University School of Medicine in 1914. He interned at the George Washington University Hospital and continued his studies with postgraduate work at the University of Chicago. He practiced in Milwaukee, with the exception of a period as first lieutenant in the army medical corps in World War I and as acting assistant surgeon in the United States Public Health Service in a Chester, Pennsylvania hos-

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pital after World War I. He spent 1925 and 1926 in postgraduate study in surgery in Vienna. Upon returning from Europe he founded the clinic which bore his name.

A Fellow of the American Medical Association, Doctor Eisenberg was also a member of the Medical Society of Milwaukee County and the State Medical Society.

Survivors include his wife and two daughters.

Dr. Homer J. Holland, 33, Mukwonago physician for the past two years, was found dead in his home on November 16. A native of South Byron, he was born on March 17, 1918.

A 1943 graduate of the University of Wisconsin Medical School, the doctor served his internship at Research Hospital, Kansas City, Missouri. He was in the Pacific for two years as a Navy medical officer during World War II, and when he was discharged he established his first practice in Mayville. He moved to Mukwonago in 1949.

Doctor Holland was a member of the Waukesha County Medical Society, the State Medical Society, and the American Medical Association.

Survivors include his wife and four children.

Dr. Jaros F. Zivnuska, retired Milwaukee physician, died on November 24 at his home, after a long illness. He was 71 years old.

Born in Prague, Czechoslovakia, he graduated in 1905 from the Milwaukee Medical College, which later merged with Marquette University School of Medicine. He established his practice in Milwaukee and was active in his profession for almost 45 years.

He was a past president of St. Luke's Hospital staff and was voted an honorary member of the staff on his retirement. He was a past president of the Wisconsin Academy of Surgery and a member of the board of directors of Johnston Emergency Hospital.

Survivors include his wife, a son, and a daughter.

Dr. Evan M. Macaulay, 78, retired Wausau physician and surgeon and former medical director of Mt. View Sanatorium, died in a Wausau hospital on December 4, after a lingering illness.

A native of Canada, the doctor was born February 4, 1873 in Balsover County, Ontario. He received his medical degree from Queen's University Faculty of Medicine, Kingston, Ontario in 1899. He was appointed medical director of Mt. View Sanitorium in 1918 and served at that post until 1947. Since that time he had conducted a private practice and served as instructor in tuberculosis at St. Mary's Hospital, until his retirement due to ill health last May.

He is survived by his daughter.

Dr. Gustave C. Eggers, retired Sturgeon Bay physician, died suddenly on December 21 in St. Louis. He was 86 years old.

Born June 4, 1865, the doctor received his medical education at the St. Louis College of Physicians and Surgeons, graduating in 1890. After practicing

medicine many years in St. Louis, the doctor moved to Sturgeon Bay. He had made his home in Two Rivers for the past year.

Survivors include his wife, a son, and a daughter.

Dr. Philip A. Panetti, 79, Hustisford physician for more than half a century, died at his home on December 16, following a short illness. He was born in Baltimore, Maryland on December 17, 1871. The citizens of Hustisford had planned to honor Doctor Panetti on his eightieth birthday, which would have been the day after his death, by gathering outside his home to serenade him with Christmas carols.

The doctor received his medical degree from the Kentucky School of Medicine in 1892, and except for a short time spent in Baltimore, practiced the rest of his life in Hustisford. He was forced to retire from practice last July because of ill health.

A life member of the State Medical Society and a Fifty Year Club member, Doctor Panetti was also a member of the Dodge County Medical Society and the American Medical Association.

Survivors include his wife, a son, and a daughter.

A Milwaukee physician since 1924, **Dr. John F. Blair,** died at his home on December 19, following a short illness. He was 58 years old.

Born in Dublin, Ireland on March 16, 1893, the doctor received his medical degree from St. Louis University School of Medicine in 1923. He interned at Milwaukee General Hospital and also did postgraduate work in medicine at the University of Pennsylvania School of Medicine. He was on the staff of the Milwaukee Hospital and on the medical staff of several industries.

Doctor Blair was a member of the Medical Society of Milwaukee County, the Milwaukee Academy of Medicine, and the State Medical Society.

He is survived by his wife.

Dr. Samuel R. Mitchell, Milwaukee physician for 35 years, died in a Milwaukee Hospital on December 21, following a short illness. He was 65 years old.

A native of Elkhorn, he was born on November 13, 1886. After graduating from Marquette University School of Medicine in 1915, he served his internship at the North Side Hospital in Milwaukee and also did postgraduate work in Chicago. He was a medical officer during World War I and reopened his office in Milwaukee in 1919.

A staff member and former chief of staff at St. Mary's Hospital, Doctor Mitchell was a member of the Medical Society of Milwaukee County, the State Medical Society, and the American Medical Association.

Survivors include his wife and a son.

Dr. William Fitzgibbon, 83, a practicing physician in Milwaukee since 1903, died at a Milwaukee hospital on December 25, following an extended illness.

Born in Eden on January 16, 1868, the doctor graduated from the Wisconsin College of Physicians and Surgeons (now Marquette University School

JUNE 30, 1952

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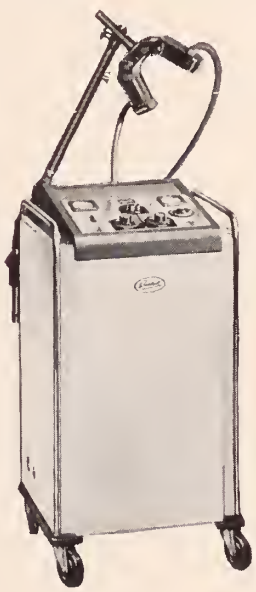

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of Medicine) in 1897. He practiced in Mt. Calvary prior to moving to Milwaukee in 1903. He was a member of the staff of St. Joseph's Hospital, Milwaukee.

A member of the Fifty Year Club of the State Medical Society, Doctor Fitzgibbon was also a member of the Medical Society of Milwaukee County.

He is survived by his wife and a daughter.

Dr. Harry G. Oakland, 74, a Milwaukee surgeon, was found dead in his automobile on December 31. Over exertion from shoveling snow from the grave of his wife was believed to have caused his death.

Born on February 21, 1878, the doctor attended the Wisconsin College of Physicians and Surgeons, graduating in 1904. He interned at St. Joseph's Hospital. At the time of his death, he was a member of the staff of Mt. Sinai Hospital and was a former chief of staff of that hospital.

Doctor Oakland was a member of the Medical Society of Milwaukee County, the State Medical Society, and the American Medical Association.

Survivors include a son and three daughters.

A retired Cudahy physician, **Dr. Bernard Krueger**, 70, died at his home on January 6. He was born in the town of Maple Grove on May 7, 1881.

After graduating from the Wisconsin College of Physicians and Surgeons (now Marquette University School of Medicine) in 1905, he practiced briefly in Westby before moving to Cudahy where he practiced until his retirement last June. He served as Cudahy's first public school physician and as plant physician for Cudahy Brothers Company in 1907 and 1908. He was also a former Cudahy health commissioner.

Doctor Krueger was a member of the Medical Society of Milwaukee County, the State Medical Society, and the American Medical Association.

Survivors include his wife, and two daughters.

Dr. C. G. Maes, retired Kimberly physician, died at his home on January 8, following a long illness. He was 86 years old.

A native of the Netherlands, he was born on August 31, 1865 and came to this country with his parents when he was four years old. He received his medical degree from Marquette University School of Medicine and established his practice in Kimberly in 1907. When the village of Kimberly was incorporated in 1910, Doctor Maes was elected its first president and he held that office for 10 years.

A past president of the staff of St. Elizabeth Hospital, Appleton, the doctor was also a life member of the State Medical Society, as well as a member of the Outagamie County Medical Society and the American Medical Association.

The only survivors are nieces and nephews.

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OFFICIAL CALL FOR

Scientific Exhibits

★

1952 ANNUAL MEETING MILWAUKEE OCTOBER 6–7–8

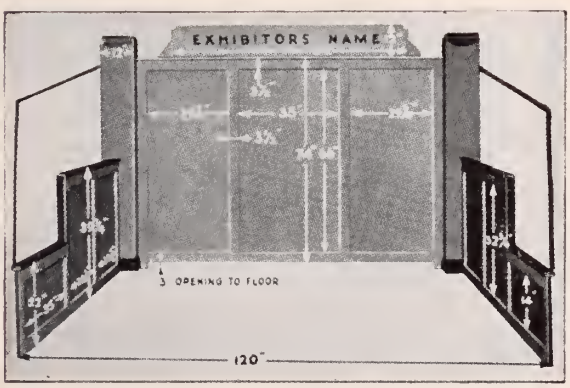
★

THE Council on Scientific Work is desirous of knowing which members of the State Medical Society are interested in presenting scientific exhibits in connection with the 1952 Annual Meeting. The exhibits will be located in Bruce Hall of the Milwaukee Auditorium.

To facilitate arrangements for the proper location of the scientific exhibits, individuals and organizations desiring space at the 1952 meeting are requested to file an application BEFORE MAY 1, giving a full description of the exhibit, the amount of space required, and the basic equipment which will be needed.

In-state exhibitors will have the following facilities provided by the State Medical Society: Wooden booth, electrical connection, shelving or tables, and identifying sign.

The exhibitor must furnish: Transportation costs of exhibit, special radiologic viewing boxes, special chrome furniture or rugs, and special lighting equipment required for this display.



In connection with the display of exhibits furnished by individuals outside of Wisconsin, the same rules as noted above will apply, but, in addition, the State Medical Society will provide hotel accommodations and reimburse the exhibit attendant for his travel, meals, and incidental expenses.

Booths for scientific exhibits are constructed of grey wood, in the dimensions shown on the chart at the left, *with this exception:* The side panels used for the exhibits of the State Medical Society are 6′ 5″ high.

Those interested in providing an exhibit are required to file an application and a full description of the exhibit by May 1. No applications can be accepted after that date. Address your communications to P. A. Midelfart, M.D., director of scientific exhibits, % The State Medical Society of Wisconsin, 704 East Gorham Street, Box 1109, Madison 1, Wis.

APPLICATION

For Participation in the Scientific Exhibit

1952 ANNUAL MEETING MILWAUKEE OCTOBER 6-7-8

Fill Out and Mail to:

P. A. MIDELFART, M. D., *Director of Scientific Exhibits*
c/o State Medical Society of Wisconsin
704 East Gorham Street
Box 1109
Madison 1, Wisconsin

1. Title of exhibit:_____

2. Description of exhibit (attach 200 word description to this blank):_____

3. The standard booth is 10′ x 10′._____

   How many booths will your display require? _____

4. Will radiologic viewing boxes be used? If so will you furnish them?_____

   (The State Medical Society does not have equipment of this character available, but it can be rented by the exhibitor through the Advertising Display and Decorations Company of Cleveland, Ohio)

5. Name of exhibitor:_____

6. Name of institution cooperating in exhibit: _____

WISCONSIN TRUDEAU SOCIETY TO MEET IN MILWAUKEE

The Wisconsin Trudeau Society will hold its spring meeting in Milwaukee on Saturday, April 5. Registration will begin at 9:00 a. m. in the East Room of the Hotel Schroeder. It is planned that the meeting will last all day, with a recess for the luncheon. The scientific program will be announced at a later date.

CORRESPONDENCE

Penicillin Sensitivity and Its Treatment

The remedies suggested for the treatment of penicillin sensitivity are many. None of them is unfailingly reliable. A very serious case of penicillin sensitivity was observed where every one of them failed to influence the unbearable itching (mainly in the palms of the hands and bottoms of the feet), or relieve the giant urticaria and swelling which covered nearly the entire body. Cortisone and ACTH were not used.

Considering the fact that the pathology in penicillin reaction is entirely in the realm of the autonomous sympathetic and parasympathetic nervous system, the use of drugs exerting an inhibitory effect upon this system suggested itself. Therefore Banthine, one tablet every six hours was prescribed. The result was astonishing. After twenty-four hours the itching ceased and swelling began to abate.

Banthine was stopped, to see whether one could credit this remedy with the favorable development. Within the next day the symptoms returned. Re-instatement of the medication had the same prompt good result. Banthine was continued for five days and then discontinued without further symptoms.

Since this apparently first use of Banthine in the treatment of penicillin reaction, six more such cases were successfully treated.—D. H. BRUNS, M. D., Milwaukee.

An Inquiry—And a Reply

December 29, 1951

Dear Sirs:

I have just finished reading the article, "Income Tax Provisions Affecting the Medical Profession" in the December issue. Although it is very helpful, I wonder if you might have additional information or suggestions for sources for the tax problems related to a partnership of two doctors. Please notify me as soon as possible. Thank you.

Yours truly,

January 7, 1952

Dear Sir:

Your letter of December 29 has been referred to me as one of the attorneys for the Society. You have inquired whether additional information or suggestions might be offered as to tax problems related to a partnership of two doctors.

We assume that you have reference to the preparation of state and federal income tax returns for a partnership and for the partners themselves. This is a matter of interest to a substantial number of physicians who practice in professional partnerships of two or more.

I am sure you appreciate that your question is extremely general and that this opinion must be correspondingly so. First of all, the only distinctive tax "problems" of a partnership are that income tax returns be prepared which reflect: first, the income from professional services or other sources, (almost universally on a *cash* basis in the case of physicians); second, all properly deductible expenses; third, the share of each of the partners in the net income as per their private agreement; fourth, the showing of those items which cannot be taken on the partnership books. One of such items is donations, which even though paid out of partnership funds, cannot be deducted by the partners as such but must be reported by the partners in proportion to their shares in net earnings. A second item is capital gain or loss on the sale of equipment, furniture, securities or other assets. Such gain or loss must likewise be transferred to the returns of the individual partners in proportion to their interests in the net income.

You undoubtedly appreciate that a partnership does not pay a tax as such under either the federal or Wisconsin income tax laws. The partnership files what is in effect an informational return. Each individual partner reports the share of profits which is his by prior agreement. If there is no formal agreement as to division of profits, they would then be presumed to share equally. The question as to what constitutes "income" and what constitutes a deductible expense of conducting a professional practice can be pretty well determined from the income tax article in the December, 1951, issue of the *Wisconsin Medical Journal*. The material is generally applicable to partnerships as well as to individuals.

Should you have any further questions of a general nature, we shall endeavor to answer them. Should you have specific questions, involving specific figures or facts, I would then suggest that you refer them to an attorney or tax accountant of your own choice.

Sincerely yours,

Legal Counsel

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Advertisements for this column must be received by the 25th of the month preceding month of issue. A charge is made of $2.00 for the first appearance of copy occupying 1 inch or less of space and $1.00 for each succeeding insertion of the same copy. Kindly accompany copy with remittance to cover number of insertions desired. Advertisements from members of the State Medical Society will be accepted without charge. Such copy will be taken out after its second publication unless otherwise requested. Where numbers follow advertisements replies should be addressed in care of The Wisconsin Medical Journal.

FOR SALE: Splendid practice, general and surgical, grossing $40,000 a year. Good hospital facilities, complete equipment, including 100 MA x-ray machine, electrocardiograph, short wave, metabolic, and many other items. Office consists of 6 rooms and bath. Doctor planning to retire in near future because of health. Address replies to No. 400 in care of the Journal.

FOR SALE: Country practice with no competition. Nothing to buy except modern residence and insulated garage, with office and waiting room in residence. $28,000 residence for $10,000. Address replies to No. 401 in care of the Journal.

FOR SALE: Surgical instruments, baumanometer, ophthalmoscope, and diathermy machine of deceased physician. Address replies to No. 402 in care of the Journal.

WANTED: By Wisconsin physician, an associate in general practice. City of 30,000 with hospital facilities. No investment, but special training desirable. Address replies to No. 404 in care of the Journal.

FOR SALE: Office equipment, medical library and instruments of deceased physician. All in excellent condition. Write Mrs. E. Panetti, Hustisford, Wisconsin.

FOR SALE: Practice and 10 room clinic equipment of recently deceased Milwaukee physician and surgeon. Office space (of 16 rooms) on ground floor available for rent in clinic building where practice was conducted for past 20 years. Excellent bus connections and unrestricted parking. Equipment includes x-ray machine, bucky table, 2 diathermy machines, 4 ultra violet ray machines, basal metabolism machine, 3 microscopes, dentist's chair, equipped laboratory, Hanover Kromayer lamp, lifetime Baumanometer, equipped pharmacy, and many specialized instruments. Address replies to No. 410 in care of the Journal.

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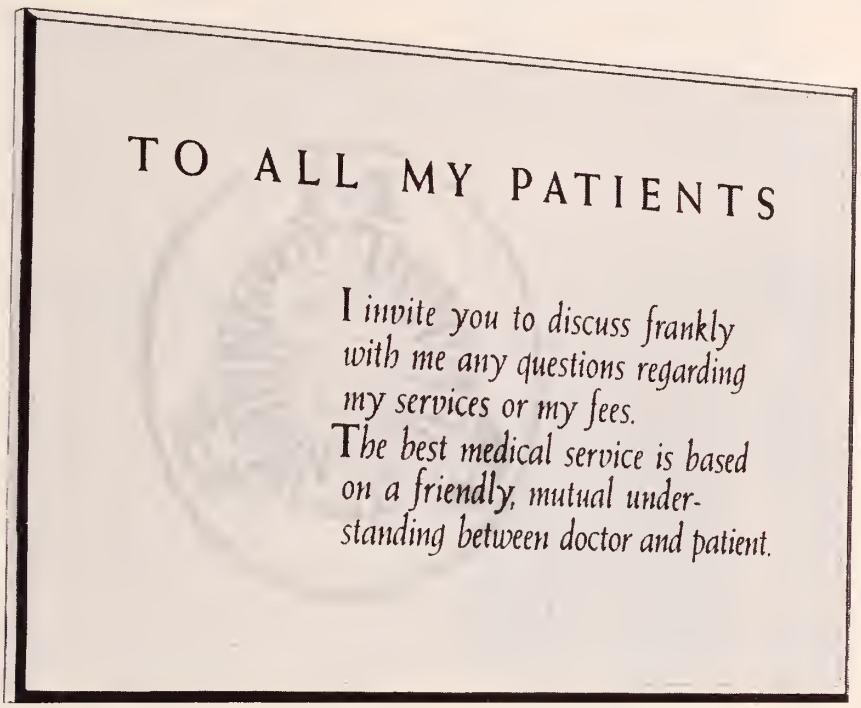

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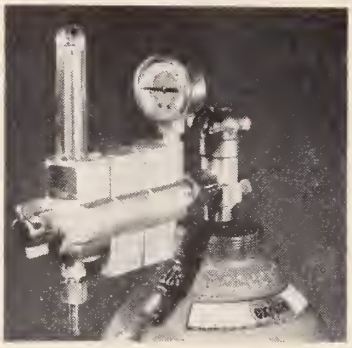

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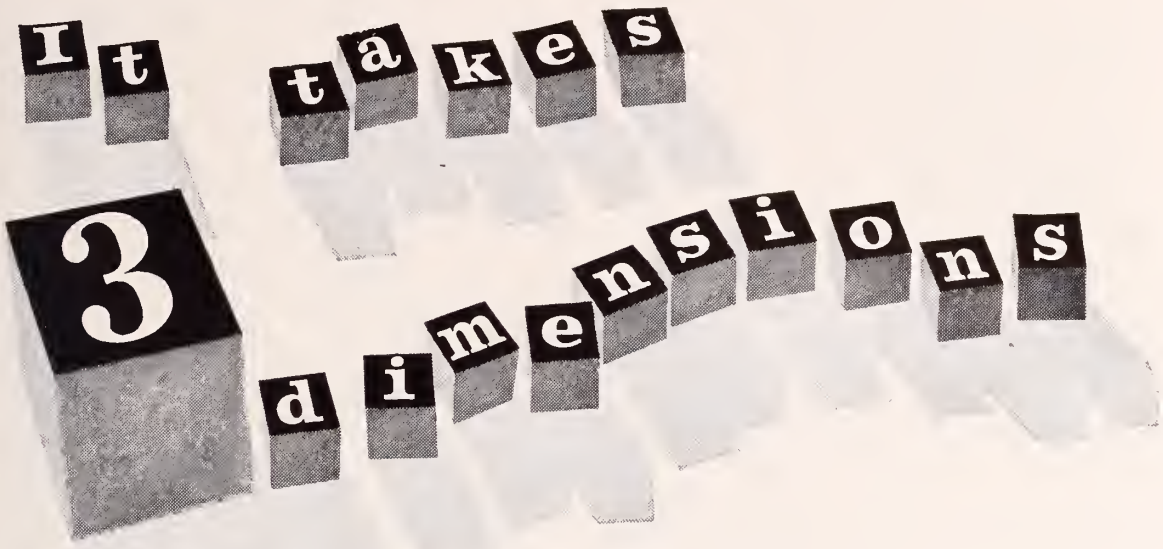

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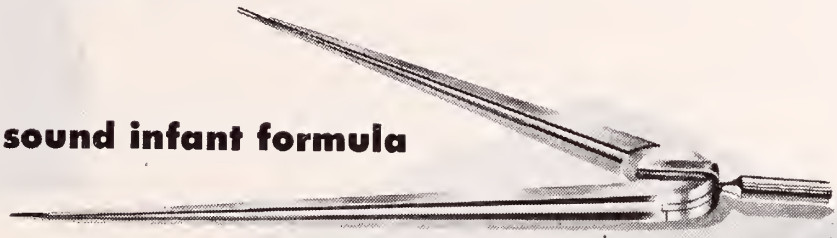

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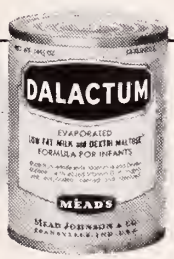

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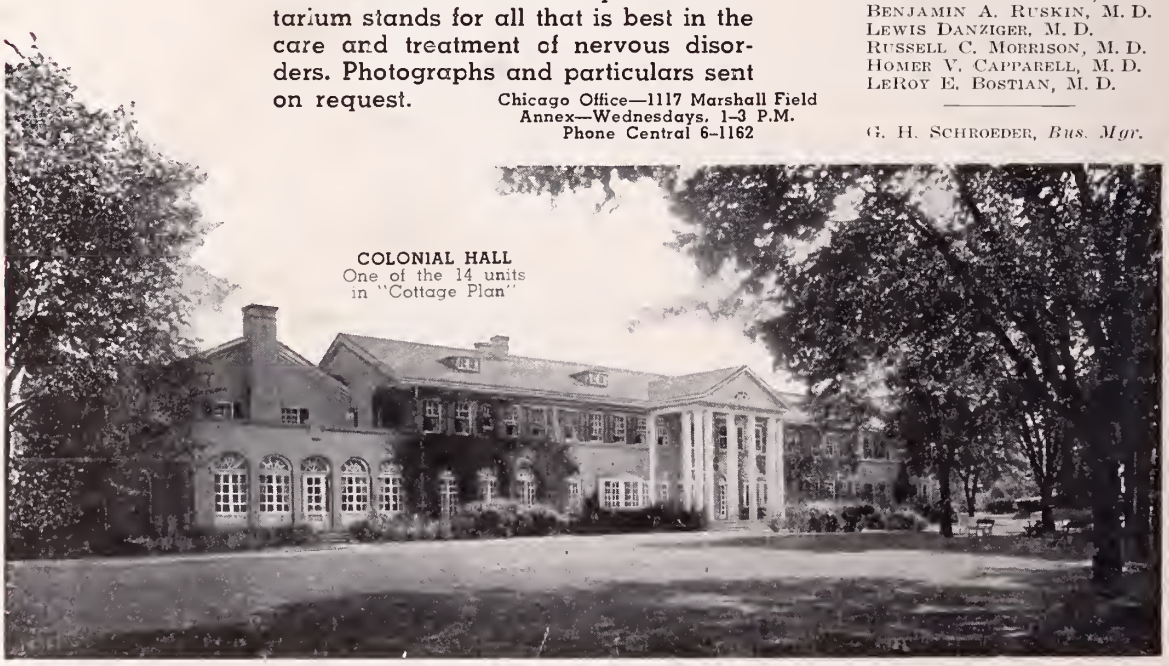

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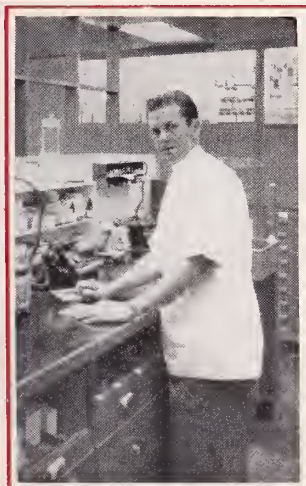

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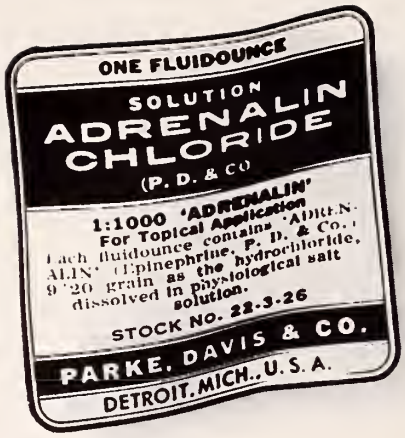

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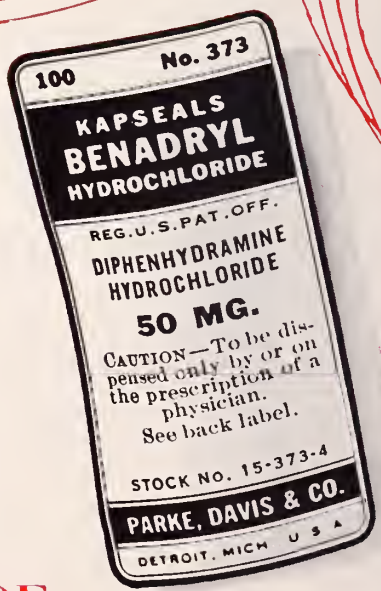

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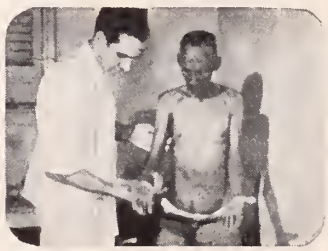

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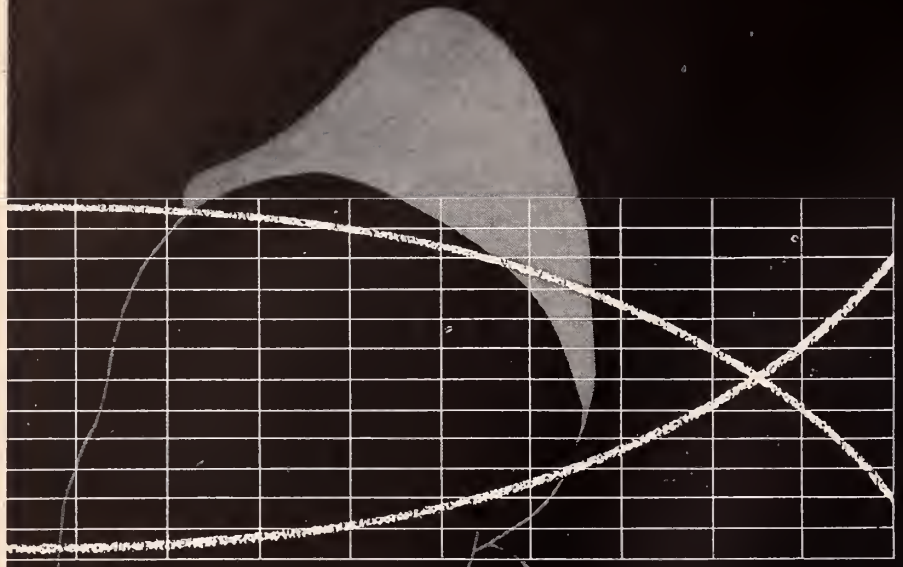

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The array of data listed below gives the approximate amounts of essential minerals provided by muscle meat when seven ounces per day are consumed.[1] The minerals include those now known to be essential components of the human organism—the skeletal framework and teeth, soft tissue structures including blood, and substances concerned in regulatory functions.

APPROXIMATE MINERAL CONTENT OF MEATS

200 Gm. (approx. 7 oz.),[1] Edible Portion (Uncooked)

	Beef Round	Lamb Leg	Pork Loin	Veal Shoulder
Minerals, total[2]	2.0 Gm.	1.8 Gm.	1.8 Gm.	2.0 Gm.
Calcium[2]	22 mg.	20 mg.	20 mg.	22 mg.
Chlorine[3]	147 mg.	136 mg.	125 mg.	147 mg.
Copper[3]	0.2 mg.	0.2 mg.	0.2 mg.	0.2 mg.
*Iodine[4] (Ohio animals)	0.02 mg.	0.03 mg.	Data not available	0.01 mg.
Iron[2]	5.8 mg.	5.4 mg.	5.0 mg.	5.8 mg.
Magnesium[3]	46 mg.	42 mg.	39 mg.	46 mg.
Phosphorus[2]	360 mg.	426 mg.	372 mg.	398 mg.
Potassium[3]	661 mg.	610 mg.	559 mg.	661 mg.
Sodium[3]	164 mg.	152 mg.	139 mg.	164 mg.
†Cobalt[5]	0.0002 mg.	———	Data not yet available	———
†Manganese[3]	0.03 mg.	0.03 mg.	0.02 mg.	0.03 mg.
†Zinc[5]	9.4 mg.	———	Data not yet available	———

*Iodine content of meat varies with the iodine content of feed of the animals.
†Needed in trace amounts only.

The average values for iron, phosphorus, and copper of the four kinds of meat shown constitute about 46, 25, and 100 per cent, respectively, of the National Research Council's recommended daily allowances for adults, and the average values for chlorine, potassium, and sodium constitute about 14, 63, and 16 per cent, respectively, of the estimated daily adult needs, as based on mineral balance studies.[6] Although no specific information is available on the quantitative needs for cobalt, magnesium, manganese, and zinc, nutrition information would suggest that the amounts reported above have nutritional importance or significance.

In addition to its notable content of essential minerals, meat also furnishes large amounts of biologically complete protein and important amounts of vitamin B complex, which includes biotin, choline, folic acid, inositol, niacin, pantothenic acid, pyridoxine, riboflavin, thiamine, and vitamin B_{12}. On the basis of its rich contribution of nutritional essentials, meat well deserves its prominent place in the daily diet of the American people, the world's best-nourished people.

1. Recent estimates of the U. S. Department of Agriculture indicate that the per capita consumption of meat in the United States approaches seven ounces per day.
2. Watt, B. K., and Merrill, A. L.: Composition of Foods—Raw, Processed, Prepared, In Agriculture Handbook No. 8, United States Department of Agriculture, 1950.
3. Estimated on basis of protein content of meats. Sherman, H. C.: Food Products, ed. 4, New York, The Macmillan Company, 1948, p. 155.
4. Ohio animals; varies with iodine content of feed. Johnson, H. J.: Bridges' Dietetics for the Clinician, ed. 5, Philadelphia, Lea & Febiger, 1949, p. 800.
5. Mitteldorf, A. J., and Landon, D. O.: Analytical Chemistry; Spectrochemical Analysis of Beef for Mineral-Element Content, Armour Research Foundation of Illinois Institute of Technology. In Press.
6. Dauphinee, J. A.: Sodium, Potassium, and Chloride Malnutrition, Including Water Balance and Shock, in Jolliffe, N.; Tisdall, F. F., and Cannon, P. R.: Clinical Nutrition, New York, Paul B. Hoeber, Inc., 1950, p. 341.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

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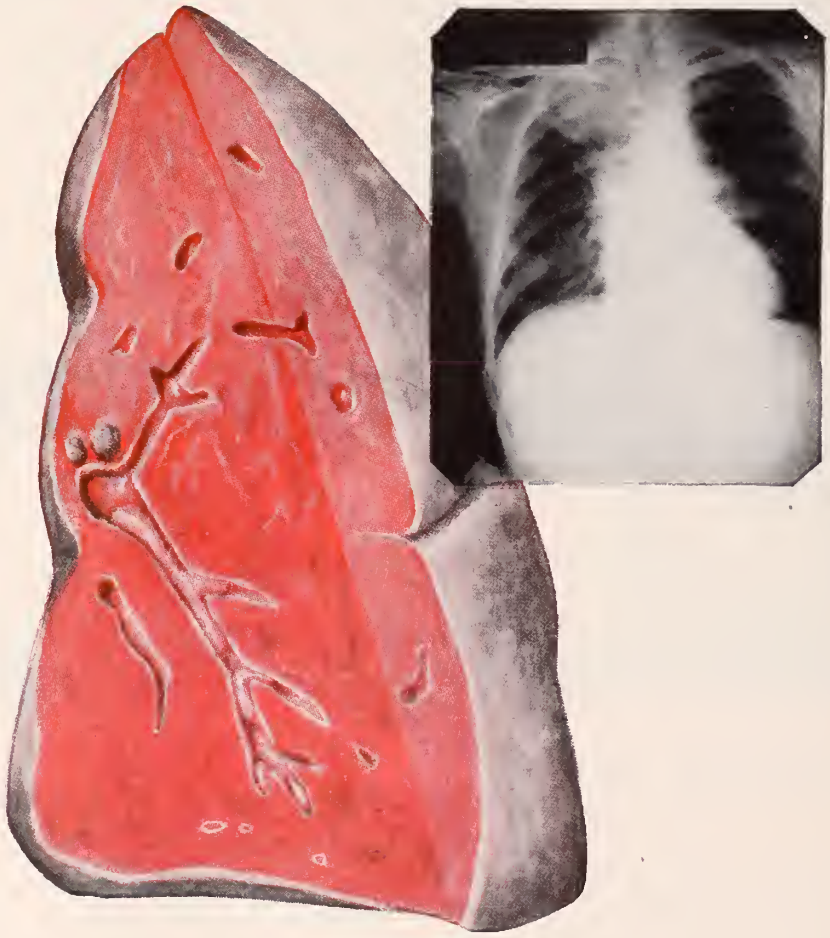

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Graves, F. B., and Ball, W. O.: J. Pediat. 39:155 (Aug.) 1951

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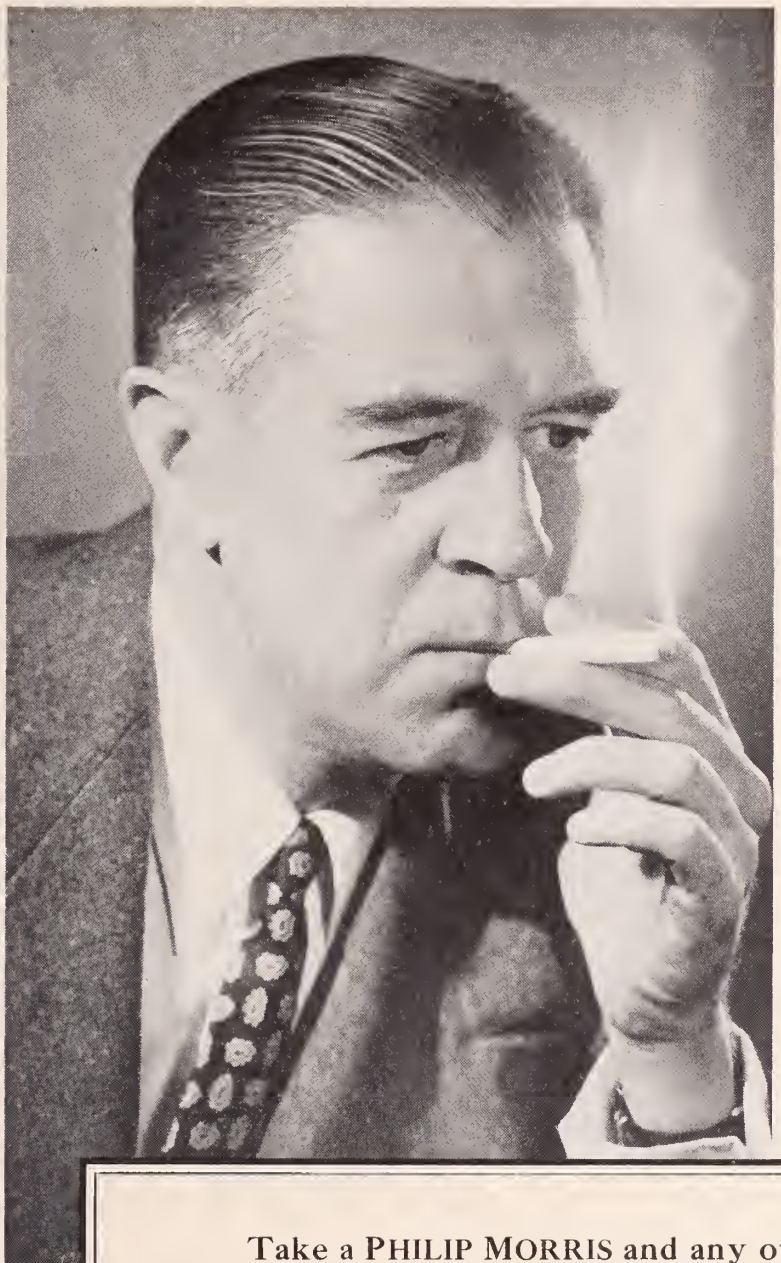

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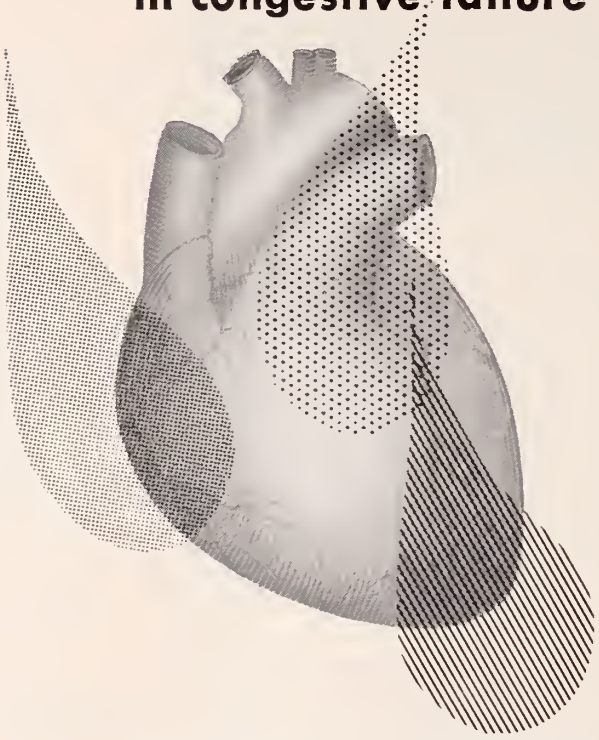

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Volume 51 MARCH, 1952 Number 3

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« « « EDITORIALS » » »

The Conquest of Space—By the Red Blood Cell*

The origin of the term "intravascular mass" is lost in the literature. The surgeon who invented it performed a service by calling to mind the vision of whole blood as having a large solid component. Indeed, the red blood cell is unique among the lean tissues of the body because it contains 35 per cent solids—mostly proteins—rather than 27 per cent solids as in striated muscle and many of the parenchymatous tissues. Recent evidence has accumulated to explain why this large solid particle is so important in blood replacement. As is so often the case, the scientist is six jumps behind the clinician, who for some years has known that for the treatment of oligemic shock there "just ain't nothing like whole blood."

Yet, understanding is a potent force, and with this knowledge sticking in his craw the surgeon is not going to tolerate for long the daily destruction of tons of red blood cells when they become outdated in blood banks. It will take us all some time to shake the dust of plasma components and colloid osmotic pressure off our feet and run to the rescue of the red cell.

The intravascular fraction of body water and the solutes dissolved in it enjoy a friendly give-and-take with sister fluids across the capillary in the interstitial and intracellular spaces. Sodium, chloride, bicarbonate, potassium, sugar, urea, albumin and many others all cross the capillary back and forth with great frequency and regularity. None of them is a stay-at-home and they all stray to far off tissues, taking with them as they wander the water they like so well. The rates at which these solutes cross the capillary are now well understood and they are extremely rapid: a review of these rates is out of place here but the reader may refresh his understanding in the literature at will.

The significance of this give-and-take is this: when a patient in shock is treated intravenously with a solution of any or all of these solutes in the form of plasma or one of its fractions or other water solutions of electrolyte, protein or synthetic colloids, these "wandering solutes" soon cross the capillary, leave the blood stream, take water with them as is their wont, and the supporting effect on "intravascular mass" is soon gone. The patient returns to shock.

*Reprinted from the January 1952 issue of the *Annals of Surgery*, pages 143 and 144.

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The red blood cell is one billion times as heavy and 600 times as long as the albumin molecule. It stays at home all its life, never wandering across the capillary to visit far off fields. It is too big, fat and heavy to escape. When we infuse it to restore blood in volume in oligemic shock, it stays right in the blood stream and adds its collective size to the intravascular mass. It increases blood volume and it stays put. The circulation is supported as will never be the case with the components of plasma or "plasma substitutes." In more than one sense the red cell is good solid support.

In an emergency, saline is better than nothing. Plasma, albumin, or one of their substitutes are of course far better than saline. With all of these solutes the scale of usefulness is ascended as an inverse function of the rate of transcapillary transfer. That rate seems to be determined largely by size. For once it is true that "the bigger the better," and the erythrocyte is the biggest and best.

The erythrocyte occupies space. It carries oxygen and transports carbon dioxide; it is an acid-base buffer by dint of its hemoglobin; but it also occupies space. Nature did not need to put hemoglobin in a 7 micron flat envelope; it is that size for a purpose, and the purpose is expressed in the fact that it is just small enough to get through a capillary lumen lengthwise but *much too big to cross its wall.* This space-occupying function of the red cell is, in treating shock, just as important as its chemical functions.

As matters now stand, the red cell has only one weakness. We cannot keep it alive in storage. Here is a research which should receive the whole-hearted support of all the national research agencies. Whether the glycerol technic, "squeezing and freezing" "drying and freezing" or some other method will prove out in the end, no one can say. But ultimately we will have nice big solid, healthy red cells many months old, for emergency use and "stock piled" along with plasma and the plasma fractions.

In the meantime, let us bring up a new generation of surgeons to appreciate the true functions of the red cell. Oxygen transport, carbon dioxide exchange, pH regulation, are all functions of a protein named hemoglobin. The function of the red cell is to contain hemoglobin and also to occupy space in the intravascular mass. No substitute will be found for the red cell until our ingenious investigators have invented a biconcave disc about 7 microns in diameter which they can produce by the trillion. Until that millenium is reached, we should be quite happy with the cell that nature has given us, and we should do our best to preserve it.—Francis D. Moore, Boston, Massachusetts.

The Passing Parade of Medicine

To say that "Time Marches On" is a trite expression of a popular slogan, but in reference to medical history it has special significance. Medicine can never stand still, nor can those who practice the art permit their minds to live in the past or even linger in the present if they hope to keep up with the advances of their vocational art. This necessity of peering into the future has destroyed a certain respect for the past which might reflect the great advances made in the science of medicine since pioneer days. Few physicians have time to be concerned with history, as they seek to keep their places in the passing parade and devote the major portion of their reading to scientific developments from the laboratories and the clinics of the nation.

Wisconsin has a rich history of medicine, with many highlights in personalities and accomplishments which should not be lost through neglect. Conscious of this fact, the State Medical Society has for many years sought to salvage old records, books, and instruments from the estates of former members. But all the while there was an awareness that a professional touch was needed to assemble much of the material which was obviously being overlooked. When the State Historical Society indicated that it had a graduate student particularly well qualified to conduct a project of search and research, it seemed to the Council a desirable project to support on a one year basis. Support from the State Medical Society, with certain matching funds from other sources, has underwritten the work of Mr. Donald R. McNeil since June 1951. The rewards, as a lasting historical memorial to the great Wisconsin physicians of the past, have been great and varied. Through the ardent efforts of Mr. McNeil many county records have been assembled and placed on file in the Wisconsin Historical Society offices in Madison. Important papers, such as the minute book of the Wisconsin Homeopathic Medical Society from 1865 to 1910 have been reviewed, and many important individual papers of pioneer physicians have been rescued from closets and cluttered attics.

In this issue of the *Journal* is a paper prepared by Mr. McNeil on a Wisconsin physician whose contribution is known to relatively few. The obvious richness of the historical material unearthed in the preparation of this biographic narrative indicates the value of professional search for medical history.

While Mr. McNeil's project has been carried on for less than a year, it has resulted in a gathering of important historical documents which it is hoped will ultimately form the core of a collection in the Historical Society headquarters to provide a better history of our pioneer members than we have had to date.

It is important to remember that what is commonplace today will have historical value tomorrow, and the Historical Committee urges all members to make their records available for incorporation into the records which will continue, through the present era, the work which has been done by Mr. McNeil this past year.

Comments from the Wisconsin Press

On the President's Commission

"A short time ago, the President announced the creation of a 'Commission on the Health Needs of the Nation.' Dr. Gunnar Gundersen, a former president of the Wisconsin Medical Society . . . was appointed a member. He immediately refused the appointment, and stated: 'I believe I am correct in assuming that the Commission is designed, both in its majority membership and in its objectives, as an instrument of practical politics, to relieve President Truman from an embarrassing position as an unsuccessful advocate of compulsory health insurance.'

"This doctor is not alone in holding such views . . . The moral is plain. The fight must continue with unabated vigor against the effort to bureaucratize the practice of medicine—and to save this country from Britain's sorry experience."—SPOONER ADVOCATE, Feb. 7, 1952.

* * *

"In the long and bitter dispute between the advocates of compulsory national health insurance and the American Medical Association, the forgotten man has been the citizen in need of more and better medical care. As one perceptive doctor put it, 'We have licked Oscar Ewing but not the problem.' That is why a new approach is vital, and why President Truman's appointment of a 15 member commission on the health needs of the nation comes as a breath of fresh air."—THE WASHINGTON POST, reprinted in the MILWAUKEE JOURNAL, Feb. 25, 1952.

* * *

A Question of Politics

"The American Medical Ass'n says it wants to keep politics out of medicine so it is going into politics this year with an organized campaign.

"President John W. Cline, says the goal will be to 'turn out of office the corrupt, power-seeking socialist planners.'

"He calls people 'socialists' who want to have national health insurance so national funds would help patients pay their doctors and hospitals."—MIDLAND COOPERATOR, Feb. 11, 1952.

* * *

Comment on a Presidential Candidate

"Gov. Warren is an excellent symbol of the liberal challenge to the Old Guard in the GOP . . . He has demonstrated by his record as governor that he means what he says. He has had the courage to defy the power of the American Medical Association by recommending a health insurance program for his state . . . He has demonstrated by his success that his kind of leadership is what the people want . . . He is a man who looks to the future and not to the past . . . He had not been afraid to adopt new and progressive ideas simply because they were first proposed by Democrats."—THE CAPITAL TIMES, Feb. 16, 1952.

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County Health Councils "On Fire!"

"The county health council idea is catching fire in Wisconsin, says the Wisconsin Medical Journal.

"It is true that the blaze has begun to burn here and there in the state . . . In the last two or three years, eight county health councils have been organized. Most of them have already got down to tackling some of the health problems of their areas.

"The idea may be 'catching fire' in Wisconsin. But in a majority of the counties it is still waiting for someone to gather the kindling and strike the match."—THE MILWAUKEE JOURNAL, Feb. 13, 1952.

* * *

"Discounted in Advance"

"The Commission on the Health Needs of the Nation . . . is to be financed from emergency funds which have been allocated for purposes of national defense.

"Dr. Gunnar Gundersen . . . a former regent of the University of Wisconsin . . . refused the appointment. . . . The Chicago Daily News said editorially, 'Precedent supports Dr. Gundersen's conclusion that Mr. Truman's interest in health is largely confined to the convalescence of his political machine. Under his auspices, the findings of the commission are discounted in advance, on the theory that he is far too cagey to risk a report that might be critical of one of his favorite vote-getting appeals.'

"The president of the American Medical Association said, 'There is no health emergency in this country to require such an investigation or to justify the use of defense emergency funds by such a commission.' "—THE BLAIR PRESS, Feb. 7, 1952.

* * *

Fighting Our Deadliest Enemy

"National death statistics for 1950 show no less than 745,000 deaths caused by diseases of the heart and blood vessels. This figure exceeds by nearly 340,000 the combined totals of deaths from five other recognized major causes.

"To be able to enlarge research and speed the day of discoveries is the purpose of the Heart Week appeals.

"Who can say this purpose may not benefit many human hearts beating today, as well as countless millions that will beat in the future?"—OSHKOSH NORTHWESTERN, Feb. 15, 1952.

Home-Town Medical Care for the Veteran*

By J. S. SUPERNAW, M. D.
Madison

THE success of an enterprise is judged by the satisfaction it gives to the people it serves and by those giving that service. I believe that the program of Home-Town Care for Veterans has answered that definition successfully.

It is the avowed intent of the Veterans Administration to render adequate medical care by doctors to all eligible veterans who have service-connected disabilities. That is also the goal of the Home-Town Medical Care Program. Dr. Joel Boone reaffirmed these intentions when he became the chief medical director of the Veterans Administration. In his address before the thirtieth anniversary dinner of the Disabled American Veterans, in Detroit, March 29, 1951, he said, "You have my unqualified assurance as a man—as a physician—as an official of the Veterans Administration—as an American—that I shall never, under any circumstances, willingly be a party to *anything* that would *in any way*, lead to the neglect of veterans who have borne the brunt of battle and are in need because of their disabilities."

Three Types of Programs

There are three basic types of programs which render service to the veteran. The old system, which was, and is, a great source of dissatisfaction to both the veteran and the doctor, is where the veteran applies to the VA for service, and may be assigned to a designated physician in the employ of the VA. A comparative handful of doctors throughout the state have been "designated" by the VA, and to one of these doctors the veteran is expected to go. If he goes to a physician of his choice, the doctor, to avoid the customary red tape for authorization, forgets his bill and takes care of the veteran for nothing. This is not good economics or good medicine!

Another system, known as the Kansas Plan, is where the state medical society agrees to cooperate with the VA by providing a list of qualified physicians who are willing to participate in the Home-Town Medical Care plan. The veteran may then select a participating physician of his choice. The clerical and administrative work, including payment for professional services, is all handled by the nearest VA office.

There are 23 states and Alaska now under such a system. One of the chief criticisms of this type of program is that the doctors, themselves, are not in control nor can they supervise their program as they do under the Intermediary system.

Under the Intermediary or Michigan Plan, there is a type of contract where the state medical society sets up an agency for handling the clerical and administrative part of the program and, in some instances, makes the initial payment to the physician. Periodically, the VA reimburses the "Agency" for professional services and, in addition, makes an allowance for the cost of such administration. At present, there are 12 states and Hawaii with this type of program, and it is the one we have in Wisconsin.

Under the Intermediary Plan the Agency is a part of the state medical society which supervises the program. The Agency acts as a clearing house for the doctors in obtaining authorization to treat the veteran and as a go-between for both the Veterans Administration and the doctor in settling problems that may come up before either. This assures better medical care for the veteran and enables the doctors to keep their own house in order.

Advantages of Intermediary Plan

The outstanding advantages for establishing such an Agency are seven-fold, and can be listed as follows:

1. To make possible a free choice of physicians by the veterans.
2. To standardize a procedure that will be time-saving for both the doctor and the veteran in obtaining authorization for treatment and billing for services rendered.
3. To interpret the rules and regulations laid down by the VA for the doctors and to represent them in altercations with the VA, and also to aid the VA in problems that confront it with the profession.
4. To assure the VA that adequate medical care will be given to the veteran, including complaints that the VA may have against the doctor for mis- or maltreatment. In short, the doctors will police their own ranks.
5. To establish a fair and workable fee schedule that can be applicable in all parts of the state.
6. To audit the doctor's bills and make it as convenient and simple as possible for the doctor to collect for his services without the customary red tape that usually goes along with governmental procedures.
7. To collect from the VA the fees due the doctor for professional services, and to see that the doctor is promptly paid for the care he has rendered.

* Presented before the twenty-fifth annual meeting of the National Conference on Medical Service, Chicago, February 10, 1952.

There is no doubt that the Home-Town Care Program is most valuable in the rural parts of the state. In the populated centers, the VA has set up its outpatient clinics and has its hospitals. These clinics, and the more-than-ambitious hospital program of the VA, will tend to destroy the purpose for which the Home-Town Medical Care Program for the veteran was set up.

Building Program of the VA

Private medicine can look with alarm upon the building program of the VA. To say it is "alarming" is to put it mildly indeed! In the Army Times Vet-Letter, Vol. VII, No. 1, of January 4, 1952, is given a list of hospitals that the VA is planning to close and also the number it plans to construct. The VA plans to construct 9,526 *new* beds and to close 3,713—a net gain of 5,813. The staffing of these hospitals must be a headache for someone! Because of the higher pay, these VA hospitals are taking nurses away from the smaller local institutions, and this may well create a serious nursing shortage. No doubt, medical staffing will be simpler as the VA can pull into these hospitals the doctors who are now serving the VA's outpatient clinics. If this were done, it would allow the veteran medical care by a physician of his own choice in his own community in those states that do not have an Intermediary Program.

In 1945, there were about 7,000,000 veterans in the United States. In 1951, this number jumped to 19,000,000! If compulsory military training becomes a law, 800,000 veterans will be added annually; and we can expect in a few years, at this rate, that most of the male population will be receiving socialized medical care through the Veterans Administration.

Now, the trend of the government is to give more medical care. The new bill, S. 2337, which was introduced by Senator Lehman, a Democrat of New York, provides more socialization than the old bill of Emergency Maternity and Infant Care (EMIC) by providing for the care of *all* servicemen's dependents and inclusion of hospital care during pregnancy.

The AMA's Reactions

Even the American Medical Association has given the "green light" to this program. In the Los Angeles meeting it was stated, "If in the indepentent judgment of the Department of Congress, the welfare of our preparedness requires that dependents and members of our Armed Forces receive medical care on a service basis, then the medical profession stands ready to provide such services through Blue Shield and other medical society sponsored plans."

Does this not mean that EMIC is approved, so long as the voluntary plans are *subsidized* by the federal government to provide medical services for all dependents of members of the Armed Forces?

Dr. Harrison H. Shoulders, a former president of the American Medical Association, has a similar idea for a national program through which the federal government would subsidize the voluntary health service plans to care for the veterans with non-service connected disabilities. Why not have local or county programs take care of these veterans? Isn't it a known fact that high quality medical care is more certain at the local level than through centralized national bureaucratic levels?

The Academy of General Practice

Recently, Dr. J. P. Sanders, president of the American Academy of General Practice, in an article in the November 1951 issue of *G.P.*, made a good case for the Home-Town Care Program by suggesting that *all* VA hospitals be either closed or turned over to local groups for operation. He did, however, make an exception and recommended that tuberculous patients, the mentally ill, and other chronically ill patients be cared for by the VA whether there is service connection or not.

Local Groups

"Why," I know you will ask, "shouldn't the local groups care for these patients too?" Local or county groups can provide all these facilities for far less money and operate more efficiently and economically than the VA ever will, to say nothing of the many advantages to the patient who will be able to remain in his own community. Socialized medicine, as administered by the VA, is as bad for one type of disability as it is for another! States, counties, and localities, in most part, have their own facilities for caring for these patients. If we are to go along with the VA plan to care for veterans with *service-connected disabilities*, then these three groups mentioned above should be cared for *only* if their disabilities are due to military service.

I believe that the Home-Town Care Program is successful and could be made to be more effective if every veteran, regardless of where he lives, could have the physician of his choice and be cared for in his own locality. This would prevent subsidizing medicine, *in toto*, by a centralized government. Why should we encourage paternalism?

Local Doctors' Reactions

I believe that Home-Town Care under an Intermediary System is successful because good medical care has been given, and has proven satisfactory, to both those giving and receiving that service. In Wisconsin, we have sent out questionnaires to the doctors participating in the program asking for their reactions to the Home-Town Care plan. In addition, I have talked to many doctors throughout the state; and with but few exceptions, they believe the plan is good. Without exception, they want the veteran to have the best of care and to protect the principle of free choice in the choosing of his physician. Many, many times I have been asked, "Why doesn't the

VA close its outpatient clinics, use those clinic doctors to staff its hospitals, and leave the care of the veteran to his family doctor for care in his own home town?"

I would like to give just a few of the answers received from the doctors in answer to our questionnaire:

"These patients (the veterans) are treated at hours convenient to their work schedule and at times when there is no waiting in the doctor's office. The result, therefore, limits the effects of their disabilities to detract from their work procedures and makes them doubly grateful."

* * *

"I will confess that I turned down quite a number of veterans for treatment because of the dreaded red tape that it implied. But since the Wisconsin Veterans Medical Service Agency is under the present setup, I have changed my attitude. I find the clerical work not too complicated and the compensation ample for the work I am doing. I have no suggestions to offer for any change but I would like to say that the plan seems to work out well for both the veteran and the family physician."

* * *

"In my opinion, the agency is a good program. I feel that it facilitates our dealings with the Veterans Administration with a minimum of paper work, which is the bugaboo with any federal administration."

* * *

"In answering your questionnaire, I can only state that I am well satisfied with the way the veteran program has been handled through your office. It gives the veteran medical care without the necessity of leaving his home and community in order to receive it. It keeps him in contact with his own physician, who perhaps has a personal interest in his welfare. I think it is also a very fine thing for the private family physician. It gives him remuneration that he would otherwise perhaps have to donate."

* * *

"I would like to suggest, however, that some forms of surgery be permitted in the veteran's home town. I certainly do not think all surgery must go to VA hospitals."

* * *

"Regarding my opinion of the program of the Wisconsin Veterans Medical Service Agency, I will state that to me it is very satisfactory. The most outstanding feature is the elimination of cumbersome paper work, which, as anyone who has ever worked for the government knows, is usually a long and tedious procedure."

* * *

"I also feel that it is doing a good piece of work because the patient has contact with a single physician rather than a physician who is part of a hospital group. His is a doctor-patient relationship which one cannot get if one has to be treated from a clinic or a hospital."

* * *

"According to my experience, this system is more satisfactory than the old VA program in every way. I would like to see it continued."

And there are many more in the same vein. The doctors are satisfied and willing to see that the veteran gets the best medical care and thus keep alive the doctor-patient relationship.

The Federal Program

On several occasions, I have heard it said that this "Home-Town Care Program" is just a trial run for the government's socialized medical program. I would like to quote from a letter from one doctor on this point. "I have recently become quite interested in the compulsory health program, particularly in Mr. Ewing's proposals and the bills introduced in Congress. In making comparisons between your program and ones introduced in Congress, my interest is aroused by the 'free choice' clause in both programs. Also in comparing your program and the S. 5, I noted that the same government will be operating both programs.

"I would like to be informed why a veteran cannot have a choice of physician and hospital since I found on page 9 in Bill S. 5, line 21, the following: 'Every individual eligible for personal health service available under this title may freely select the physician, dentist, nurse, and medical group, hospital or other person of his choice to render such services and may change his selection.'

"Every time I recommend hospitalization for a veteran, I am requested to fill out another form that will send the individual to a veterans hospital.

"I also noted that a physician is unable to earn more than $6,000 a year. Does that hold true under the new proposals in the Ewing plan?

"If the federal government wishes physicians to believe in these proposals, why can't the promise become effective in the programs that are now operating?"

Complaints Against the VA

And the doctors have other complaints about the Veterans Administration. Common complaints are as follows:

1. There is a delay in authorizations when service records have been lost or misplaced.
2. Requests for additional treatment are denied if they come in a day or two late.
3. The physician is penalized by having his bill held up until some minor infraction has been cleared.

The physician knows that the veteran is the one who is hurt, when authorization or payment for a service rendered has been denied, because the doctor was late in getting his paper work in on the minute.

There is complaint also that well-qualified men are denied authority to perform procedures on the basis that veterans must be sent to a VA hospital for "re-evaluation and/or treatment."

There *is* too much "paper work," too much emphasis on "time" and as one doctor aptly stated, "That time is more important than the veteran."

Let me quote from a letter from the chief medical officer of our Veterans Administration. "We note in your correspondence that the doctor states he forgot to note his recommendations on Form 200, but that services were rendered March 5, 12, and 22. Notification of this fact, of course, reached us after the fifteen day limit had expired. Authorization for these services is being denied."

It is a little difficult to explain to the doctor that even though the disability was established to have been service-connected, and he has rendered the service, he will not be paid, just because he was busy and got in his "paper work" too late!

We have suggested means which would simplify and eliminate some of the duplication and waste of time. For example, the VA could issue the veteran, so entitled, a card defining his service-connected disability. When in need of medical attention, he could present this card to his physician and would receive care. We believe that the doctor is not a chiseler. This is borne out by the fact that he has turned down thousands of dollars for treatment which has been authorized. In this alone, Wisconsin doctors returned 22 per cent of authorized treatment. Why not allow the doctor, who cares for the veteran, to determine the treatment and the amount of treatment needed without tearing his hair to see that his "paper work" gets in on time?

There are more gripes, but I know, in general, the doctor is doing a good job. He is satisfied because *he* is running his own business through the officers of his state medical society.

What Does the Veteran Think?

Now, what does the veteran think about Home-Town Care?

To find this answer we alphabetically selected 50 veterans each month and asked them for their comments. Listed below are a few of their answers:

"If it were not for home-town treatments, I would lose more time at work. I would have to try and get more disability to offset the loss in wages."

"I think the treatment is okey. More convenient for me."

* * *

"I believe the home-town plan is very good. As for me, I can continue to work during part of the treatment."

* * *

"This is a fine setup for the veteran."

* * *

"It provided a house call for me when I had severe insulin reaction."

* * *

"Home-town care helps keep the veteran out of already crowded VA hospitals."

* * *

"This plan has been very satisfactory to me, as I have had to have treatments for the past five years."

* * *

"I appreciate home-town care very much. I have received treatments that have been very beneficial to my health without leaving my home or job."

* * *

"I appreciate home-town medical care. If I had to go to the VA office, I would waste a day's time, besides the cost of transportation and the inconvenience. I am not feeling well. I am near a doctor who knows my case."

* * *

"Home-town medical care plan is a very fine plan in my opinion. If I had to receive treatment at a veterans clinic, I would not get the individual attention required. It also is a convenient plan because it eliminates travel to another city for treatment."

I can go on and on as we sent out hundreds of these cards, and our response was over 99 per cent!

I think you will find the same reactions and get pretty much the same answers from Michigan, Minnesota, California, and the other states which have the Intermediary Plan for the care of their veterans.

I believe this plan is successful because it renders good medical care and gives satisfaction to both the doctor and the veteran.

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110 East Main Street.

MARQUETTE MEDICAL ALUMNI ASSOCIATION WILL HOLD CLINICS

The Marquette Medical Alumni Association will hold its annual Spring Clinics at the Medical School on Saturday, March 29. Physicians throughout the state are invited to attend the program of lectures and discussions on medical topics. A luncheon for the physicians in attendance will be given by Parke–Davis and Company at the Stratford Arms Hotel. Plans also include the presentation of an award to the outstanding medical alumnus of the year and an informal dinner dance at the Wisconsin Club.

Diagnostic and Therapeutic Significance of the Nasopharynx*

By WALTER H. THEOBALD
Chicago, Ill.

THERE are few specialties in medicine for which the nasopharynx is completely without interest. To the neurologist it is an area where involvement is capable of producing an interesting array of cranial nerve involvements from the first to the twelfth nerves. To the ophthalmologist the involvement of the third and sixth nerves not infrequently presents bizarre eye symptoms. To the surgeon who is concerned with swellings of the neck, the nasopharynx, as the site of primary neoplastic disease, must ever be borne in mind. To the otolaryngologist the region of the epipharynx represents the source of postnasal secretion, recurrent sore throats, cough, earache, fever, and hemorrhage, in addition to those conditions already mentioned.

Too often in routine examinations of the nose and throat, a critical survey of the epipharynx is omitted or considered of such little importance that it is frequently dismissed with only casual inspection. The nasopharynx has been labeled the "unknown," the "neglected area," but these titles can be qualified by emphasizing four possible errors in examination: (1) not seeing the epipharynx; (2) not knowing what to look for; (3) not interpreting and evaluating correctly what is seen; and (4) not looking at all.

The technic for nasopharyngeal study is simple and provokes no undue discomfort to the patient. The methods for this examination consist of anterior and posterior rhinoscopy, use of the nasopharyngoscope, x-ray visualization, and direct nasopharyngoscopy. The latter method is best accomplished by means of a palate retractor or preferably the Yankhauer Speculum. This, to me, is the instrument of choice and the most serviceable because it provides a direct view of the vault and also allows for instrumentation at the same time. Probing with a cotton-tipped applicator will reveal the depth and limitations of a pouch, as well as the overgrowth of lymphoid tissue. When the mere touch of an applicator provokes bleeding, it is evidence that inflammation or granulaton tissue is present.

In many instances the epipharynx is revealed by rhinoscopic inspection. When the turbinates are shrunken and the septum is not obstructive, it is easy to observe the vault through one side of the nose while probing this field through the other side with a small cotton-tipped applicator. For the study of neoplasms, choanal fibroma, or polypi, the Mischel Mirror provides adequate inspection. For examination of lesions around the eustachian tube orifice and in and about Rosenmüller's fossa, the nasopharyngoscope is the most serviceable.

Diseases of the nose and sinuses and allergy must be eliminated before all evidence can be placed against the nasopharynx as a primary focus for postnasal symptoms. The history alone is often indicative of the diagnosis. The sudden appearance of a mucoid clump in the mouth is the typical description given by the patient when a pouch is present.

The most common symptoms complained of are postnasal discharge, recurrent pharyngitis, cough (often paroxysmal), headache, persistent fever, bleeding, hoarseness, or asthma. In many instances the onset of recurring rhinitis has its origin in the vault of the epipharynx. The patient often states, "I have a burning sensation back of my palate."

Examination of the postnasal space reveals a wide variety of findings. The pharyngeal bursa (Thornwaldt's bursa) has an opening into the sac which varies in size from that of a pin point opening to a vertical slit, or a large elliptical opening. It may give the impression of a mere cul-de-sac, or it may be closed completely having the appearance of a bulging abscess. The content may be purulent, cystic in character, or jelly-like mucus. When the sac is infected, the lining appears reddened and there may be lymphoid tissue or granulation tissue within the sac.

The more common type of pathology encountered is lymphoid hypertrophy which results from repeated inflammations to form linear furrows or retention cysts. This hypertrophy may be sufficient to be termed an adenoid growth. Thus no constant finding in the epipharynx is typical of one particular symptom or another. They are all intimately related, and the significance and interpretation of findings should be given conscientious evaluation as to the cause of symptoms. Ulcerative processes may be tuberculous, or syphilitic or caused by blood dyscrasias.

The bacteriologic study of the epipharynx is not particularly informative except in cases of persistent fever. In a series of 150 cases studied, the predominant organisms recovered by culture were nonhemolytic streptococcus, Streptococcus viridans, hemolytic staphylococcus aureus, and diphtheroids. In patients with chronic fever, however, hemolytic

*Presented before the One Hundred and Tenth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1951.

streptococcus was the predominant organism, while in cases with closed bursas, cultures often proved sterile.

One should be constantly alert to the possibility of neoplasms in the nasopharynx. They may be malignant (mainly anaplastic) and also benign. The usual site for these growths is the posterior pharyngeal wall; the roof of the nasopharynx; and the lateral wall, encroaching upon the tubal orifice.

The symptoms and signs indicative of tumor growth are nasal blockage, continuous "head colds," feeling of a foreign body, hemorrhagic secretion or hemorrhage, cough and sore throat, speech alteration (rhinolalia clausa), hearing loss, pain, asymmetry of palate, jugular foramen involvement, and diplopia. Too often the first evidence of malignancy is discovered through biopsy of an enlarged cervical lymph node. This clue usually prompts a nasopharyngeal examination to reveal the primary source. These cancers occur most commonly in patients between the ages of 40 and 60. The most frequent type encountered is highly malignant squamous cell carcinoma. In 40 per cent of the cases reported by Nielsen, cervical gland enlargement was the first symptom observed. Biopsy of any suspicious growth may be accomplished either through the Yankhauer Speculum or rhinoscopically.

Histologic studies in a number of cases revealed varying degrees of chronic inflammation, and at no time was normal respiratory epithelium found. The surface covering showed transitional epithelium with squamous metaplasia, and the stroma gave evidence of chronic inflammation by the presence of round cell infiltration and proliferation of fibroblasts. Some sections evidenced greater round cell infiltration than others, indicative of more intense chronic inflammation.

In reporting a series of cases I should like to emphasize the importance of a thorough study of the epipharynx in all individuals who have a low grade fever of unknown origin. In a survey of 150 cases, there were 8 with a history of persistent fever for a period of five months or more. In one case it was present for 18 months. The temperature ranged from 99 to 100 F. Three of these patients required surgery, while the others were treated conservatively. The systemic symptoms were constant fatigue, neuralgia or arthralgia, and sometimes loss of weight. The diagnosis was based upon the fact that no specific or local cause other than the epipharyngeal pathology was found. All of the patients were studied by an internist for the cause of the obscure fever. In this particular group the sedimentation rate and white blood cell count were only slightly elevated, if at all. Furthermore, sulfonamide and penicillin therapy had been administered without any influence upon the course of the temperature. Final diagnosis was definitely established when the temperature returned to normal and the symptoms disappeared following treatment of the infected epipharyngeal tissue.

In this series, 10 patients complained of frequent colds which had their origin in the epipharynx, the onset of which was described as a burning sensation above the palate. There were 9 cases of acute epipharyngitis with fever. Bleeding, in the form of bloody expectoration or cough, was observed in 6 cases. Three of these patients were suspected of having pulmonary tuberculosis, and 2 of them had received sanatorium care, although no acid-fast bacilli had been discovered. One case of postnasal hemorrhage was severe enough to have previously required postnasal packing, and one had received blood transfusion. Bleeding granulation tissue was seen in the midline of the vault by direct nasopharyngeal examination. Histologic study was negative for neoplasm. This patient was treated by electrocautery employed locally, supplemented with rutin and ascorbic acid.

In 16 cases of this series, cough was a major symptom—nonproductive and paroxysmal in character—sometimes described as a "tickling sensation" and not relieved by the usual sedatives. Lymphoid hyperplasia with hyperemic and thickened lateral bands behind the posterior pillars was the predominant finding. There was prompt relief following local treatment to this area. Hoarseness or laryngitis was present in 10 cases, secondary to postnasal discharge. Asthma was relieved in one patient in whom all other forms of treatment, including allergenic therapy, had failed. A large, bulging, closed pharyngeal bursa, with a pin point opening allowing the escape of purulent secretion, was discovered in one patient. Another patient complained of impaired nasal breathing, and a closed bursa with a bulging vault was found. The sac contained thickened, jelly-like mucus. Removal of the sac gave complete relief of symptoms in both instances.

One case of tuberculosis of the nasopharynx is reported not as a symptom per se of the disease, but because pulmonary involvement was a known factor. The so-called "postnasal drip" complaint led to the diagnosis of the primary source. This patient had a superficial ulcerating lesion, ovoid in shape and covered with a grayish exudate, in the vault of the epipharynx. Tubercle bacilli were recovered by smear examination. It is advisable, therefore, to bear in mind investigation of the epipharynx in cases of pulmonary tuberculosis. The healing effects of streptomycin in tuberculous lesions of the larynx and oropharynx have been dramatic. Its application to lesions of the nasopharynx have been reported as equally effective.

Intermittent otalgia with fullness and hearing impairment was the primary complaint in 11 cases. With the exception of two adults, these were all children under 16 years of age. Tonsils and adenoids had been removed previously. The tympanic membrane picture was varied, but it gave evidence of serous exudate or inflammation. In a few cases myringotomy and inflation with recovery of fluid confirmed the ear findings. The presence of massive

lymphoid tissue or adenoid growth in the children required surgery, or radium, or both.

This study included 58 males and 92 females ranging in age from 5 to 75 years. In 40 per cent of the cases the most frequent complaint was postnasal discharge, thickened in consistency and yellowish in color, sometimes foul in taste, and occasionally noted as a mucoid, inspissated clump in the nasopharynx. The latter usually suggests a true pharyngeal bursa. Thirty-five per cent of the patients in this series gave a history of repeated sore throats or chronic pharyngitis in which cervical adenitis was sometimes present, accompanied by low grade fever. The occasional sore throat which appeared in the morning and subsided during the day was a typical example.

The presence of a bursa is frequently noted without clinical symptoms. To be pathologic the sac must be infected. This may follow trauma, such as occurs in removal or scraping of adenoid tissue. The incomplete removal or the presence of adenoid remnants is a frequent cause of lymphoid hypertrophy and subsequent formation of retention cysts, abscess, or chronic inflammation. In my opinion the adenoid operation is perhaps the poorest and most inadequate of our surgical procedures because too much is dependent upon "blind" palpation. Elevation of the palate or the use of the Love retractor should be used for inspection of the vault after adenoid removal in order to be certain that remnants and tags are not allowed to remain.

Treatment of these cases consists of surgery, irradiation, and local therapy. When massive hypertrophied lymphoid tissue is present, surgical removal is indicated.

Local treatment is accomplished by the application of 5 per cent silver nitrate through the Yankhauer Speculum, or it may be possible in some instances to make this application through the nasal speculum. The use of a small cotton-tipped applicator is recommended so as to avoid an excessive amount of solution which might run down into the pharynx. More intensive caustic materials are to be discouraged because of probable subsequent destruction of mucus glands, crusting, or scar tissue formation. In 2 of the cases reported, however, electrocauterization was employed when bleeding was the most prominent symptom. Trichloracetic acid was applied in 2 other cases in this series.

Radium was employed only in those cases in which the condition did not respond to conservative local management. There are certainly limitations for irradiation, and the indications for its use should be carefully evaluated. In fact its application is being viewed with disfavor as we study the results of irradiation some years after its use. Its effect is only on young lymphoid tissue and not of a permanent nature. Therefore, a note of caution should be sounded concerning the indiscriminate use of radium for treatment to the epipharynx. One should inquire always as to whether or not the patient has had previous radium therapy. Certainly, it should not be applied when no discernible pathologic condition is present in the nasopharynx, nor should it be employed solely on the basis of ear findings. Furthermore, lymphoid tissue can regenerate following such therapy, and it is possible to have metaplastic changes take place. How can it be known in what percentage of cases the stimulating effects may bring about neoplastic formation in years to come? Further observations and studies are necessary before the true permanent effects of irridiation therapy can be evaluated.

307 North Michigan Boulevard.

1952 ESSAY CONTEST ANNOUNCED BY AMERICAN SOCIETY OF PLASTIC AND RECONSTRUCTIVE SURGERY

The Foundation of the American Society of Plastic and Reconstructive Surgery offers awards in junior and senior classifications for original contributions in this field.

Junior Classification: Two six month scholarships in leading plastic surgery services in the United States, England, and Italy will be awarded.

Senior Classification: The Foundation's annual prize, a silver plaque, will be given for the best essay presented at the annual meeting of the Foundation.

The contest is restricted to residents and surgeons in the practice of plastic and reparative surgery for not longer than five years. The subject matter of the essay should be the result of some original clinical or laboratory research in plastic surgery of recent date. All essays should be submitted in quadruplet form in English with no indication of the writer's name or his institutional affiliation, but should be identified by a legend. This legend should appear on the outside of a sealed envelope which contains the name, address, and affiliations of the contestant.

All entries must be received by the award committee not later than September 1, 1952. Further inquiries should be addressed to: The Award Committee, % Jacques W. Maliniac, M. D., 11 East 68th Street, New York 21, New York.

Coarctation of the Aorta

By JOSEPH W. GALE, M. D.*
Madison

COARCTATION of the aorta is a congenital cardiovascular defect which may be classified according to two types: (1) The infantile, where there is a narrowing of the isthmus of the aorta between the left subclavian artery and the ductus arteriosus, and (2) the adult, where the stricture occurs at about the level of the ductus arteriosus or ligamentum arteriosum. Coarctation of the infantile type is seldom compatible with life since there are usually other serious malformations of the heart. If the ductus arteriosus was unusually large during intrauterine life, there was no reason for the development of a collateral circulation to carry the blood to the lower extremities. After birth the collateral circulation cannot develop rapidly enough to sustain life. Because of this it becomes obvious that the majority of cases seen and those which are eligible for surgical treatment are of the adult type.

The history of coarctation is interesting and its recognition dates back almost 200 years. It is not within the scope of this paper to enter into the history or the physiopathology of this disease, but excellent discussions and bibliographic data can be found in articles by Christensen et al[1] and Bing et al.[2]

The importance of coarctation of the aorta is easy to understand since it comprises about 10 per cent of the cardiovascular defects in man. It is more common in the male. The prognosis is grave as far as longevity is concerned and depends upon the degree of the stenosis and the adequacy of the collateral circulation. Reifenstein, Levine, and Gross[3] reviewed the postmortem material from the larger hospitals in Boston to determine the fate of persons suffering from coarctation of the aorta. They found that 26 per cent lived a long life with little or no incapacitation. Twenty-two per cent died from subacute bacterial endocarditis or aortitis. These individuals did not have the advantage of receiving antibiotics which are now available to control the disease. The question arises as to the number who, if they had been treated in the modern way, would have still suffered with residual myocardial damage. Twenty-three per cent of the patients died suddenly from rupture of the aorta, and 28 per cent died because of hypertension. The deaths from cardiac failure were about twice as common as those from intracranial hemorrhage. If the deaths from incidental cases were excluded, they found that the average life expectancy of patients with the disease was only 30 years. Certainly, these findings are not greatly different from those which Abbott[4] and Blackford[5] have reported. They clearly demonstrate that the prognosis is grave in at least 75 per cent of the cases unless definitive measures are instituted to correct the inadequacy.

Coarctation of the aorta is not difficult to recognize if the examiner is alert to the possibility of its presence.

The physical findings encountered are easily interpreted and pathognomonic of the disease. There is a distinct difference in the arterial pulsations in the upper and lower extremities. There is a strong systolic thrust in the upper extremities and a feeble or absent pulsation in the femoral arteries. The pulsations, if palpable in the femoral vessels, are slightly delayed since the blood must follow a circuitous route through the collateral circulation before reaching them. If blood pressure readings are recorded in the upper and lower extremities, it will be found that it is markedly elevated above and greatly reduced or absent in the popliteal artery. In the normal individual the blood pressure is higher in the lower extremities. Careful observation of the patient will frequently show a very florid face and neck, with visible pulsations in the latter. The shoulders and upper thorax are extremely well developed, and in these individuals visible pulsations over the anterior chest wall, particularly in the region of the internal mammary arteries, are present. Other pulsations may be seen and felt in the interscapular space along the inferior scapular region and in the axilla. All of these are evidence of a well developed collateral circulation.

Examination of the heart will usually show only minimal changes. The disease is primarily in the aorta, and no characteristic heart murmurs are present. The heart has gradually adjusted itself to the increased load and is essentially normal until there is a break in compensation. Eyeground changes are in keeping with those of hypertension.

X-ray examination is of definite value. Early in childhood no changes may occur. After the first eight or ten years of life certain definite x-ray findings appear which are pathognomonic. The heart may be enlarged. The aortic knob is absent or very small. Infrequently, a notching may be noted in the aorta. The ribs will show a distinct notching at the lower edges in the posterior axillary line. This phenomenon is due to the erosion of bone by the tortuous and greatly dilated intercostal arteries. The most commonly involved ribs are the fourth to the eighth. The notching is bilateral but not necessarily symmetrical. X-ray findings may be entirely absent.

*From the department of surgery, University of Wisconsin Medical School, Madison, Wisconsin.

Since it is not possible by x-ray examination alone to determine the extent of the lesion, further study by angiography may be indicated. A Diodrast solution is rapidly injected into an arm vein and followed through the great vessels and aorta. A second and more reliable method, that of Craaford,[6] is to introduce a cardiac catheter through the radial artery and down into the aortic arch. An injection of 50 to 70 cc. of Diodrast is rapidly given and provides a clear visualization of the aorta and the stenosed area.

The differential diagnosis is usually not difficult. Essential hypertension can be readily ruled out by the presence of a femoral pulse. We have seen one such case that was referred to the State of Wisconsin General Hospital for sympathectomy, and during study was found to have a coarctation. Other diseases such as rheumatic heart disease and aneurysm offer little diagnostic difficulty.

The first successful surgical treatment of coarctation of the aorta in the human being was reported less than a decade ago. Crafoord and Nylin 1945,[7] and Gross and Hufnagel[8] reported their first successful cases. The foundation for these successes, however, had been laid previously by the research of Blalock, Park,[9] and others. Craaford receives credit as the first to perform this operation. Since then, numerous articles have appeared in the literature reporting series of many successful cases.

The surgical technic employed in this operation has varied among the many surgeons. The success of the operation is dependent upon close teamwork between the cardiologist, surgeon, and anesthetist. As in all intrathoracic operations a great responsibility falls upon the anesthetist. We have been especially fortunate in having well trained anesthetists capable of administering good intratracheal anesthesia with well controlled respiration. In our earlier cases cyclopropane was the agent of choice, but we have now come to believe that ether is far safer and much more satisfactory.

Precautions are taken preoperatively to insure facilities for ample blood and fluid replacement during the operation. Needles inserted into ankle veins before operation are valuable insurance against any catastrophe. The surgical approach in each instance has been through an adequate posterolateral incision. The fifth rib is resected throughout its length, and the fourth and sixth ribs divided at the transverse processes before opening the thoracic cage through the periosteal bed of the fifth rib. A rib-spreader is placed and adequate exposure, which is mandatory for good surgery, is obtained at the outset. Frequently the blood loss is heavy while entering the chest because of the well developed collateral circulation in the chest wall. This can be minimized, however, if care is exercised. The lung is retracted downward and the aorta inspected. One is struck by the size of the intercostals and the left internal mammary artery. The aorta usually appears to have a notch opposite the site of the ligamentum arteriosum. This does not appear marked but looks larger after the mediastinal pleura is incised. Gradually the aorta at the site of the constriction is isolated and mobilized. Great care must be exercised not to injure the intercostal vessels which have a very thin wall. Once the mobilization is complete one notices the appearance of the aorta. It is slightly smaller above the constriction but enlarges immediately below and then tapers gradually to the normal size. If the coarctation is palpated there may be a thrill, but a thickening is always present. A specially designed clamp is placed above and below the stricture, and the coarctation excised. Usually about 1 to 1½ cm. is adequate. The proximal and distal ends are then sutured with 4–0 silk with an over and over suture. Some surgeons prefer an everting suture. Either is satisfactory, but we have felt that there is less tension and a little length obtained with end to end apposition. We also feel there is less liability of a breakdown in the suture line. After completion of the anastomosis, the distal clamp is removed, followed promptly by the proximal one. Any suture hole leaks are readily controlled with Gelfoam. The mediastinal pleura is closed, the lung inflated, a tube inserted for suction drainage, and the chest wall closed.

There will be occasional cases where the coarctation assumes hourglass proportions, and after excision it is impossible to bring the ends of the aorta together. This occurred at times in our group of cases. A substitute anastomosis can be used as first suggested by Clagett.[10] The left subclavian artery can be anastomosed to the distal aortic segment. In each instance where we have employed this procedure a satisfactory anastomosis has resulted.

This report is concerned with a series of 20 cases which have been admitted to the State of Wisconsin General Hospital over a period of four years. Table 1 shows the condition in this group of cases to be equally distributed as far as sex is concerned. The oldest patient was 37 and the youngest 8 years of age. The average age was 19 years. The predominating symptoms were headaches, dyspnea on exertion, easy fatigability, cold feet, and weakness of the lower extremities. The highest preoperative blood pressure recording was 210/112 in the upper extremities. It was impossible to obtain blood pressure readings in the lower extremities in 13 instances. All cases had the adult type of coarctation. Nineteen had resection of the coarctation with one of two types of anastomosis. Excision with end to end suture was performed in 14 cases, while 5 cases had an anastomosis between the subclavian artery and the aorta. In 2 cases the coarctation was of the hourglass type, one measuring 3 cm. and the other 4 cm. in length, respectively. In one case an attempt was made to perform an end to end suture between the widely separated ends. This proved unsuccessful because the sutures tore. In the other 3 cases the constriction lay at the base of the subclavian, and it was thought dangerous to trust the efficiency of a clamp with such a short proximal segment.

TABLE 1

Patient Sex Age	Symptoms	Blood Pressure Preoperative		Operation	Blood Pressure Postoperative		Result
		Arm	Leg		Arm	Leg	
A.H. F 27	Dizziness, headache, weakness	210/112	0	Excision; end to end suture.	125/70	140/85	Well
E.O. M 17	Headache, dizziness, palpitation	186/116	0	Excision; subclavian to aorta suture.	164/74	136/116	Improved for three years.
W.F. M 12	Fatigue, rheumatic heart disease	150/90	0	Excision; end to end suture.	140/70	130/100	Well
J.C. M 18	Palpitation, headache	160/84	100/76	Excision; end to end suture.	122/70	124/70	Well
J.R. M 18	Dyspnea, headaches, numbness in legs	150/90	105/95	Excision; end to end suture.	145/80	150/90	Well
R.D. M 22	Dyspnea on exertion	208/100	0	Excision; end to end suture.	210/110	180/100	Dead
B.D. F 26	Dyspnea, headache, cold feet, fatigue	190/110	0	Excision; end to end suture.	134/70	160/120	Well
R.G. M 24	Precordial pain, weakness of legs	140/90	0	Thoracotomy only.	148/96	0	Unimproved
J.M. F 16	Cold feet, cramps in legs, headache	170/108	0	Excision; subclavian to aorta suture.	140/90	150/100	Well
C.L. M 11	Easy fatigability	165/110	0	Excision; end to end suture.	136/70	140/90	Well
E.B. F 31	Headaches, palpitation, dyspnea	210/110	130/100	Excision; subclavian to aorta suture.	130/70	150/90	Well
J.R. F 10	Headaches	170/120	114/100	Excision; subclavian to aorta suture.	134/100	100/70	Well
P.W. F 14	Dyspnea on exertion, fatigability	118/60	100/90	Excision; end to end suture.	110/72	120/90	Well
J.P. F 8	None	130/100	0	Excision; end to end suture.	95/80	?	Well
E.S. M 37	Previous cerebral accident	200/110	0	Excision; end to end suture.	130/84	122/76	Well
M.E. F 16	Rheumatic fever 4 years previously	140/108	?	Excision; end to end suture.	120/80	?	Well
R.K. F 24	Dyspnea, headache, substernal pain for 4 years	175/110	110/105	Excision; end to end suture.	124/78	148/90	Well
A.LaM. M 15	Headaches, cold feet, fatigue	140/90	?	Excision; subclavian to aorta suture.	126/96	?	Unimproved
M.M. F 24	Headache, dyspnea, easy fatigability	190/130	104/94	Excision; end to end suture.	132/82	140/76	8 months pregnant. Well
J.B. M 15	Hemiplegia 6 months before, residual	170/100	?	Excision; end to end suture.	145/80	150/115	Well

Now that better clamps are available, we would perform the aorta to aorta suture. It is better, where possible, to perform the end to end suture since the volume of blood flow is greater. The volume can be increased if, when the subclavian is used, it is cut on a bias, thereby increasing the size of the anastomosis.

A thoracotomy only was performed on one patient, R.G. This patient had an adult type of coarctation lying at the base of what was thought to be the left subclavian artery. Further examination revealed that the left common carotid and the left subclavian arteries branched from the aorta as a common trunk. Any constriction applied to permit

the anastomosis would have occluded both arteries. Previous to the operation the patient insisted that no chances be taken with his life. In view of this and the dangers involved, the anastomosis was not performed.

Two patients had had cerebral accidents, E.S. and J.B. The older, age 37, had completely recovered before operation. He was also the oldest patient in the series. In spite of his age and history he has enjoyed a complete recovery and is working long hours against the advice of his physicians. The second patient, age 15, although operated on only about six months ago, is continuing to clear his residual and is now enjoying excellent health.

One patient, A. LaM., is unimproved since operation in spite of a successful anastomosis. His referring physician reports he is probably worse. Previous to operation he had a heaving systolic thrust at the base of his neck on the left side. This persisted after the operation. At the time of the anastomosis there was what was thought to be the right subclavian artery coming from the aorta below the base of the left subclavian. We preserved this vessel, but there are probably other abnormalities present which are contributing to his unimproved condition. This patient must be considered an operative failure. One other patient, E.O., was improved following operation, but his hypertension still persists. It is interesting to note that this patient and A. LaM. both had subclavian to aorta anastomosis.

One patient, M.M., was three months pregnant at the time of operation. Immediate postoperative recovery was complete. Upon her return home she noted dizziness, and her physician noted rapid fall in blood pressure when upright. At times the systolic pressure would fall to 70 mm. mercury. Wrapping of the lower extremities and a tight belt improved this condition. It will be interesting to see how she endures her first labor less than one year following operation.

Sixteen patients are well and performing their ordinary activities. Fourteen of these had end to end aortic suture and 2 had subclavian to aorta suture. The ideal situation after operation is for the blood pressure in the upper extremities to return to a level normal for the individual's age and the absent or greatly lowered pressure in the lower extremities to rise to a slightly higher level. This has occurred in only 10 of our cases. In two instances, although the patients are well, no blood pressure is obtainable in the lower extremities. The reason for this has not been adequately explained. One may postulate that further improvement in this will take place as years pass. Two patients in whom excellent results were obtained had rheumatic heart disease previous to operation.

One patient, R.D., died ten days after operation. He was apparently making an uneventful postoperative recovery until the sixth day when he suddenly went into profound shock. This was treated in the usual way, and his blood pressure stabilized at a normal level. Thoracentesis on the left revealed a massive intrapleural hemorrhage which had apparently ceased. We felt it advisable to delay operation until his condition improved. Four days later he was scheduled for evacuation of the hemothorax. Early that morning he again suffered profound shock and was taken to the operating room where the thoracotomy wound was opened and the source of the bleeding found. The second left intercostal artery had been divided at the time of the first operation. It was found to have sloughed from the wall of the aorta. The ligature on the stump was found intact. The bleeding was controlled, and the patient returned to his room in poor condition where he expired two hours later. Postmortem examination revealed a vegetation in the wall of the aorta at the site of the intercostal artery, and further studies revealed the presence of a staphylococcic septicemia which had gone unrecognized. The aortic anastomosis was intact.

Summary

Twenty cases of coarctation are reported. Successful anastomosis was performed in 19 cases.

Sixteen patients (80 per cent) are leading normal lives.

Two patients are unimproved or improved, 10 per cent.

One patient is dead. Operative mortality was 5 per cent.

1300 University Avenue.

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Visual Aids as an Adjunct in Starting the Psychotherapeutic Process in Psychosomatic Conditions*

By O. SPURGEON ENGLISH, M. D.**
Philadelphia, Pa.

THAT emotional factors disturb body physiology is often a puzzling and difficult concept for the psychosomatically ill patient to understand. To prepare a patient for treatment and to bring about a transition into definitive psychotherapy is often difficult for the practitioner because of the lack of adequate technics to explain this basic concept.

One of the best devices to get the psychotherapeutic process under way is through the use of charts which show the patient just what is happening to him from both the physical and the mental point of view. Elementary as these charts may seem to be, they nevertheless have proven most effective in bringing about cooperation and establishing rapport between the patient and physician. They have been developed after years of thought and experimentation and prove once again that visualization does speed the process of understanding. It is hoped that the physician will find them of help when the presence of psychosomatic disease has been established and psychotherapy is beginning.

The psychosomatic concept developed in the 1930's as a natural outgrowth of psychiatry's knowledge of neurosis. It is, in reality, an extension of this knowledge of neurosis, but it embraces more disturbances in body physiology than conversion hysteria, anxiety hysteria, and neurasthenia. It includes such entities as colitis, mucous colitis, disturbances in rhythm of the heart, migraine, and disturbances in the function of the gastrointestinal tract.

Emotional Conflicts Cause Symptoms

Most physicians understand this, but unfortunately many patients do not. Often it becomes a tedious and difficult task to impart this knowledge to a patient and get him interested in it. When I first started practice, I found it difficult to get patients to understand what a neurosis was. Now, the same holds true of psychosomatic illnesses. It is amazing how often it is difficult to help a patient understand that emotional conflicts cause distressing symptoms to arise in the body.

Patients resent the vagueness of terms such as "nerves," "nervousness," and "neurosis." When one adds "psychosomatic" to the list, they like it no better and understand it no better. They feel these terms imply weakness, extra sensitivity, difficulty in managing one's personal problems—in other words, mental illness. And so it does, but with one major deviation from former concepts. There is no longer an onus attached to mental illness. It is neither shameful nor incurable. It is a common, everyday malady that affects many wonderful people. There are thousands of individuals suffering from neuroses and psychosomatic conditions. They are competent individuals. They contribute a great deal to life, but the fact remains that they have difficulty resolving conflicts. They are, in some degree, emotionally ill.

Psychosomatic Concept Hard to Accept

To make this clear is difficult indeed. Both patients and physicians find it hard to accept. However, the fact remains that as people attempt to do big things, as they attempt to meet their responsibilities in this chaotic world, and as they attempt to solve problems, there are some who by virtue of their training and experience are going to have conflicts. And as these conflicts arise, or as life forces them into difficult situations, such as service in the armed forces, war, or other catastrophes of civilian life, emotional conflicts arise that result in disturbances of the physiology. These disturbances we call neurotic symptoms; we call them psychosomatic conditions.

Psychiatrists accept this concept of neurosis or psychosomatic illness, but there are still many physicians and patients who cannot work together constructively toward health around this concept. I cannot overemphasize how many people close their minds to it. Physicians find it difficult to explain. Patients do not like to have the words "neurosis" or "psychosomatic" applied to them. It is, as I have said, a worrisome, disturbing and sometimes insulting thought. People find it uncomplimentary and too vague and nebulous.

It is suggested, therefore, that to make this important phenomenon more acceptable and better understood, charts be used as an aid to the physician for as many sessions as is necessary to make the patient familiar or "at home" with the idea.

Charts Aid Physicians

These charts have been prepared in simple, elementary terms. They show faces depicting certain emotions. And they show how these emotions, which originate from centers in the brain, find their way

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**Professor and head of the department of psychiatry, Temple University Medical School and Hospital, Philadelphia, Pa.

TABLE 1.—*Syndrome of Psychosomatic Disease*

Status of Patient	His Need From Physician	Means of Accomplishment
1. Possessor of distressing symptoms	To be given explanation for symptoms—neutralize fears of disease.	Example Analogy Charts Pictures (Stills and Movies)
2. Possessor of personality with remnants of childhood emotions such as over-dependency, excessive love needs, resentment, hostility, envy, jealousy.	Show that self protection or self defense is neither necessary to nor productive of health. That anxiety and/or deprivation are disturbing physiology.	Explain early life effect of social training upon physiology, and the later effects of conflict and regression upon body function.
3. Tends to avoid reality Tends to avoid responsibility Tends to protect self Tends to pamper self Tends to defend immature way of thinking and acting	Acceptance of human nature which helps patient to understand and accept childlike or immature emotions in himself and aids him in correcting them.	Regular appointments. Faith in ability of patient to change. Try to see that patient receives some rewards of more mature behavior. Treat relatives if necessary.

through definite pathways to disturb body physiology and produce pain. That this takes place in a variety of conditions is also shown. They *help* to tell the psychosomatic story and prepare the patient for therapy. The charts are not *the* psychotherapy itself.

Most patients and many doctors have difficulty accepting psychosomatic concepts. Often the doctor feels relieved and happy to be able to say to his patient, "You will be glad to know there are no psychosomatic disturbances—it is just something organic." This may leave the patient a little confused, and not quite sure if he is satisfied or not, but the doctor most assuredly is.

The above table is a condensation of the method usually followed in the psychotherapeutic process in psychosomatic disease. A history is taken, and a thorough examination made of the patient. When no organic disease is found and the patient is still the possessor of distressing symptoms usually with clearly defined personality problems, a diagnosis of psychosomatic illness is made. What the patient then needs from his physician is an explanation for these symptoms which will help to neutralize his fear of disease. If this explanation is successful, the patient may give up his belief that his illness is due to organic causes. To accomplish this, use is made of analogies, examples, charts, and pictures.

Movies, it has been found, are very effective when used in group psychotherapy, particularly when the disturbances center around upper gastrointestinal disturbances, cardiac arrhythmia, dysrhythmia, or anxiety about the heart. There are excellent movies available that give an understanding of underlying psychopathology.

How to Use the Charts

To first explain to the patient how mental pain causes physical discomfort he is shown a chart of a cross section of the body organs and a magnification of neural connections. This chart clearly demonstrates that there are definite pathways which carry nerve impulses from the emotional centers in the brain through the spinal cord and autonomic nervous system to all tissues controlling and modifying (1) muscle tonus, (2) blood supply, and (3) gland activity.

Once this important phenomenon has been shown as a tangible cause or reason for local disturbance of an organ, the physician can pass to whatever chart pertains to the illness or organ under discussion.

The next chart shows the neural connections of the stomach and indicates how emotions can affect the muscle tonus, gland activities, and its blood supply. This chart becomes a little more human and more related to the patient's own psychologic problem. Here he can see how envy, jealousy, sorrow, love needs, fear, resentment, rage, frustration, ambition, and selfishness specifically can affect the stomach.

Additionally, this chart can be used to help the patient admit that he has experienced some of these emotions himself, or that some one of these emotions are present in him at the moment. Usually he will admit to this. Then he can be shown that others who have suffered from the same psychosomatic illness as he is suffering have had the same emotional reactions as he. It is then an easier step for the physician to proceed with a further discussion of these emotions from the point of view that they upset body physiology. On this chart the faces depicting these emotions surround a picture of the brain showing the emotional centers in the brain emanating these conflicts through nerve pathways directly to the stomach.

Emotions Affect Heart Rate and Rhythm

The next chart in a similar way demonstrates how emotions can affect the heart rate and rhythm.

The emotions most commonly found in those suffering from cardiac neurosis or any irregularities of the cardiac rhythm are as follows: anxiety, worry, hostility, frustration, envy, jealousy, love needs, and insecurity.

It should be noted that there are certain common denominators in all neurotic and psychosomatic conditions. These charts show the overlapping of emotions common to all psychosomatic conditions. The concept of specificity is an important one, and certain emotions are prone to produce distressing cardiac symptoms. However, one should not at-

tempt to fit the patient too rigidly to a formula of specificity but rather to understand and try to solve his most important life problems.

Another chart explains the mechanism of headache and helps the patient to understand that emotions can produce pain following changes in the caliber of the cerebral blood vessels.

Common Cause of Headaches

Lack of emotional tranquility is the commonest cause of psychogenic headache, and it often represents concealed resentments and frustrations as can be clearly seen by the distorted faces depicted on this chart. They show how anxiety, insecurity, frustration, dissatisfaction with life, hostility, self-centeredness, and resentment cause alternate contraction and expansion of arteries that determine distress or discomfort. This produces changes in the flow of the blood in the blood vessels. It occurs at the time of the headache-producing incidents or sometimes hours later. Headaches, as it can be seen on the chart, are dull-headed monsters created by the hostility and anxiety, surrounding ambition, competitiveness, and disillusionment. Those suffering from headaches are in some way "hitting their heads against a brick wall" because they see no solution to their problem or refuse to make one.

Fatigue as produced by emotional stress and strain as well as physical stress and strain is next portrayed. In this chart one sees faces showing the lack of enthusiasm, the insecurity, the resentment, ambivalence, depression of spirit, frustration, irritability, the need for love, the dissatisfaction with life, which is usually found in the neurasthenic individual. The tired housewife and the tired white collar worker are typical of those who cannot cope with life's responsibilities and resort to fatigue as a means of escape. The person who constantly suffers from undue fatigue is very often the one who falls most closely into what is known and described as a neurasthenic.

Obesity Can Be Due to Conflicts

Eating may bring gratification which is not obtained through healthy emotional outlets. The next chart shows a well-padded couple, typical of those suffering from obesity, simultaneously reading and reaching for the candy box. They are portrayed as fat, self-centered, frustrated individuals, with a great need for love in the form of sensuous gratification. They suffer from anxiety and dissatisfaction with life, and their unconscious emotional conflicts beset them constantly.

There seems to be a limited renunciation capacity in obese individuals that makes it almost impossible for them to give up the food which gives them some pleasure and gratification. Their basic unhappiness seems to be so great that it can be understood why food and sweet things, at least, give them some extra gratification. They seem to rationalize with themselves by thinking, "To be thinner would be nice, but I'll start dieting tomorrow. I'll enjoy what I eat today, because at least it makes me happy now." That tomorrow, of course, never comes because their deep emotional conflicts never allow it.

Emotions can produce migraine by periodically altering blood vessel caliber. The same emotional conflicts that cause headaches seem to cause migraine, with the added suffering that comes to the individual afflicted with ambivalence. Persons with strong neurotic tendencies and deep emotional imbalance seem most prone to develop migraine. They are prone to be ambitious, competitive people, and hence aggression is a prominent personality trait. Alternate contraction and expansion of arteries determines the amount of distress or comfort.

Because of the excruciating pain and suffering felt by the individual, this chart shows the pain of migraine as a horrible combination of whining wheels, slamming doors, and loathsome drills attacking the head. Envy, jealousy, insecurity, and ambivalence are seen influencing the emotional centers and causing the extraordinary suffering. The patient suffering from migraine will usually identify quickly with the figure in this chart.

Skin Chart Effective

Emotions may adversely affect the healthy functioning of the skin. Amazing results are often achieved when a patient suffering from certain skin disturbances finds out he is really suffering from emotional disturbances. When the need for approval,

TABLE 2.—*Typical Case Presentation—Syndrome of Gastrointestinal Distress*

Status of Patient	His Need From Physician	Means of Accomplishment
1. Conviction of illness as result of distressing symptoms	To be given explanation for symptoms—neutralization of fear of disease.	Example Analogy Charts Pictures (Stills and Movies)
2. Drive to protect self, nurse self, doctor self, love self back to health.	To be taught that self interest is valueless, even harmful, and that to ignore self and serve others is productive of strength.	Re-education Encouragement Approval Follow-up interest
3. Passive, dependent character, wanting love and care, and unmotivated to responsibility. Often conscious drive to superiority.	A parental interest which accepts him and his passivity but encourages him to achieve more mature philosophy, without overcompensated drive for superiority.	Interest in progress Follow-up visits Encouragement Making him aware of the rewards of mature behavior.

is recognized, when the patient understands that his ambivalence and oversensitivity are causing his skin to be oversensitive, quite often his symptoms begin to disappear. This chart is of help in showing the patient how the emotional centers in his brain affect the nerves which in turn affect the healthy functioning of the skin.

Psychotherapeutic Process Follows

After the charts have served as an introduction to the psychotherapeutic process, the physician can proceed with efforts directed toward a discussion of conflicts, needs, tensions, and their solution. He can try to show the patients that they still possess remnants of childhood emotions which they have not overcome. The physician can teach them that their task is to understand these emotions and see where and how, in their immediate environment, they can overcome them, and find release from them. The physician can help patients to learn how they can, instead of suffering from their symptoms, gain some relief through self understanding and work out of them by adopting new points of view. Patients must learn that self protection and self defense is neither necessary nor productive of health, and that the anxiety and deprivation from which they are suffering by their limited way of life is disturbing to physiology.

When this process is underway, the patient is accomplishing results by psychotherapy. When this is achieved, the patient has some understanding of the meaning of his psychosomatic illness.

These visual aid charts which have been described are available in pamphlet form for those who may want them.* A typical case history is also presented with the charts as an added aid to the physician.

3401 North Broad Street.

*From Sandoz Pharmaceuticals.

INSTITUTE ON THE SLOW LEARNER SCHEDULED FOR APRIL 26

The second annual statewide Institute on the Slow Learner will be held at the University of Wisconsin Memorial Union, Saturday, April 26. Its purpose is to increase public understanding of Wisconsin's 35,000 mentally retarded citizens and to present various facets of current care, training and education which are being provided them, by public and private services, in their homes, in school, on the job, in their community as well as in institutions.

The state's top authorities in this field will participate. All meetings are open to the public. They are variously geared to the interests of doctors, nurses, institutional staff, physiotherapists, teachers, physiologists, social workers, clergy, parents, and interested citizens.

Among the sponsors of the Institute are six state agencies, eight voluntary organizations and the three largest parent groups in the state. Further information may be obtained by writing to Room 206, University Extension Building, University of Wisconsin, Madison 6, Wis.

SUMMER CAMP SCHEDULED FOR DIABETIC CHILDREN

A summer camp for diabetic children will be opened for the fourth season under the auspices of The Chicago Diabetes Association, Inc. from July 1, 1952 to July 22, 1952 at Holiday Home, Lake Geneva, Wisconsin.

In addition to the regular personnel of the camp, there will be a staff of dietitians and resident physicians, trained in the care of diabetic children, furnished by The Chicago Diabetes Association.

Boys and girls, ages eight to fourteen years inclusive, will be accepted at a fee of $120.00 (which covers the three week camping period and transportation from Chicago). Fee reductions may be arranged when considered necessary.

Physicians are requested to notify parents of diabetic children and to supply the names of children who would like to attend camp. Applications may be obtained from, and inquiries should be addressed to: Service Unit, Chicago Diabetes Association, 110 South Dearborn Street, Chicago 3, Illinois.

Limited capacity requires prompt application.

American Gynecology Around 1850

By ERWIN H. ACKERKNECHT, M. D.
Madisan

JUST about a hundred years ago, American surgeons were privileged to play a significant role in the opening of a new era in gynecology. While as a whole America was still more of an importer than an exporter of medical knowledge during the nineteenth century, gynecologic surgery was among the few exceptions where progress was initiated on this side of the Atlantic.

There was, in the words of Howard A. Kelly, "beginning with McDowell and Marion Sims . . . a new gynecology springing up, full of life and vigor, sturdy, independent and aggressive, about to disown all but a remote kinship with the pining maiden allied to obstetrics, still wearing a pessary, woe-begone with an irritable uterus and bed-ridden with hysteria." Kelly mentions on the other hand as typical American representatives of the "uncertain, fragmentary, speculative and pottering gynecology of the ancients" the books of Dewees (1826) and H. L. Hodge (1860). This comment is perhaps applied with more justice to Hodge than to Dewees.

American promotion of the new gynecologic surgery started with the ovariotomies reported by Ephraim McDowell (1771–1830) of Danville, Ky. Edinburgh-trained McDowell performed his first ovariotomy (for relief of ovarian tumor) in 1809, published the first article on ovariotomies in 1816, and seems to have performed the operation thirteen times, with eight successes. Not enough credit can be given to this man who, in the isolation of the backwoods, dared and succeeded in an operation which appeared impossible to the ablest surgeons of the great European clinical centers many decades later. McDowell, who in 1812 performed a lithotomy on James Polk, later president of the United States, seems to have been a gifted surgeon.

Ovariotomy was performed sporadically after McDowell. Around 1850, two other Americans, the brothers Atlee, established ovariotomy, against considerable resistance, as a routine procedure in their own communities. The older of them, John Light Atlee (1799–1885), who spent his professional life in their home-town, Lancaster, Pa., started performing ovariotomies in 1843. He did 78, with 64 successful operations. He did 2,125 major operations and 3,264 deliveries during 65 years of active practice.

The younger brother, Washington Lemuel Atlee (1808–1878), who in 1845 moved to Philadelphia, did 378 ovariotomies. Among the pioneers of ovariotomy in the United States, E. R. Peaslee (1814–1878) of New York and Robert Battey (1828–1895) of Rome, Georgia, should also be mentioned. Battey introduced oophorectomy, that is castration, in 1872 for ill defined conditions, such as neurosis. This was a case of American pioneering in gynecology that made its author internationally famous at the time, but the absence of which would probably leave us today without regret. Theodor Gaillard Thomas of Edisto Island, S. C. (1831–1903), author in 1868 of a famous treatise on gynecology, inaugurated vaginal ovariotomy in 1870. Thomas served, like Peaslee and Sims, on the staff of the famous New York Women's Hospital for many years.

Through Washington L. Atlee's myomectomies, on which he started publishing in 1853, America inaugurated another important branch of gynecologic surgery, the removal of uterine tumors. Gilman Kimball of Lowell, Massachusetts (1804–1892) performed in 1853 the first deliberate and successful hysterectomy for fibroma.

The most spectacular American contribution to gynecologic surgery, and that which found the widest international acclaim and is best remembered was James Marion Sims' (1813–1883) successful operation for vesicovaginal fistula, that most dreadful condition that made life unbearable without destroying it. Sims published a most attractive description of his adventurous life. A native of Lancaster, S. C., he made his great discovery in 1849 while practicing in Montgomery, Ala., after four years of scores of experimental interventions upon negro slave women. Before developing his fistula operation, Sims introduced a new position for examination and a new speculum, accomplishments that with some of his contemporaries, like T. G. Thomas, rated higher than his operative procedures. In 1853 Sims moved to New York and succeeded—against the attempts of his colleagues to copy his technic, but to keep himself out of business—in founding the Women's Hospital in 1855. In 1861 he made a triumphal trip to Europe, and from that time forward divided his attention between the two continents, recognized in both as the leading gynecologic surgeon.

His collaborator and successor in the Women's Hospital, Virginia-born Thomas Addis Emmet (1828–1919) was hardly inferior to Sims as a surgeon and was also a picturesque personality. He, too, published an interesting autobiography. He developed Sims' clues and has been called the first great vaginal plastic surgeon.

Sims' partner in Montgomery, Ala., Nathan Bozeman (1825–1905) who toured Europe in 1858 and moved to New York in 1866, was apparently also an able gynecologic surgeon. The extensive need for reparative surgery and the existence of so

many fistulas and perineal injuries show that many deliveries were either poorly or not at all supervised during this period.

The flourishing of gynecology in the United States brought about in due time the foundation of special journals and associations. At the first meeting of the American Gynecological Society in 1876, German born Emil Noeggerath (1827–1895), who had since 1857 practiced in New York, gave a paper on latent gonorrhea in females, which then found just as much opposition as it later found deserved recognition. Noeggerath was also one of the founders of the *Journal of Gynecology* in 1868, and introduced ovariocentesis vaginalis in 1869.

Although American obstetrics was not as outstanding in this period as gynecology, it has some fine accomplishments to its credit; the biggest, of course, was the demonstration in 1843 by Oliver Wendell Holmes of Boston (1809–1884) of the contagiousness of childbed fever. Of the two Philadelphia professors who were the opponents of Holmes, the one, H. L. Hodge (1796–1873), did some good work on the birth mechanism in sectioning casts of the pelvic outlet. He also invented a pessary. The main function of the other, C. D. Meigs (1792–1862), a rather prudish individual, seems to have been the fighting against any worthwhile innovation, be it Holmes' explanation of childbed fever, the use of ether anesthesia in childbirth which was introduced by Walter Channing of Boston in 1846, (In 1842, Channing had also first described pregnancy anemia.) or Atlee's ovariotomy. This strange obstetrician opposed even the manual examination of the female organs or the clinical teaching of obstetrics, as introduced by James Platt White of Buffalo (1811–1881) in 1850 under an outburst of indignation of laymen and doctors. That American gynecology survived the moralizing hypocrisy of the gilded age appears as a sheer miracle. One thing must be credited to Meigs. Writing on gynecology in pure purple prose he unwittingly produced some of the funniest books of all times. Philadelphia obstetrics had come down a long way since Shippen had introduced so successfully the tradition of William Hunter.

Marmaduke B. Wright of Cincinnati (1802–1879) described in 1854 a cephalic version very similar to that invented by Braxton Hicks in 1860. John Stearns of New York (1770–1848) had introduced Secale cornutum (ergot) into scientific obstetrics in 1807. In 1847 he was elected the first president of the New York Academy of Medicine and died the next year from an infected autopsy wound.

Many of the outstanding gynecologic surgeons were Southerners, but all tended to end up in New York City. Most of them were trained exclusively in the United States, a fact practically unknown in outstanding American internists of the period.

This leads to one of the reasons why America excelled just in gynecologic surgery. The strict division between physician and surgeon and the professional and social degradation of the surgeon in the middle ages, the consequences of which were felt in Europe far into the nineteenth century, had never been imported into this country. Any kind of medical personnel had to be simultaneously a surgeon. Thus American surgery never showed the same lag, when compared to European surgery, that was so often exhibited by American medicine; and American surgery at times even surpassed European surgery. The somewhat adventurous and daredevil character of a young nation might also have created in surgeons and patients, alike, favorable psychologic conditions for new departures in surgery.

The particular rise of gynecologic surgery might have something to do with the higher appreciation of women in an immigrant country, where they enjoyed rarity value, and with frontier conditions, where they were irreplaceable. It should not be forgotten that McDowell, Sims, Atlee, Battey, etc. made their discoveries under frontier conditions. Sims describes how he saw the campfires of the Indians when he rode at night through the Alabama countryside to visit his patients. As to Sims' negro patients, they had a very definite monetary value that could be realized only after repair of their fistulas. Another explanation of the rise of American gynecologic surgery might be that there was less postoperative infection in the isolated hamlets of the American frontier than in the crowded hospitals of the large European centers. Also the frontier offered a less favorable cultural medium than Meigs' Philadelphia for the suicidal bashfulness which forbade visual or tactile examination of the female genitalia. One must in all honesty admit that these points may give some reasons, but are far from explaining the whole phenomenon.

From the peaks reached by modern gynecology it seemed worthwhile to look back at these first steps, less in a sense of complacency than in a sense of intellectual curiosity. Other backwoods may still hide other McDowells and other Simses.

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Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

Papaverine Suppositories in Myocardial Infarction

It has been my practice in the past to employ vasodilator and sedative medication orally and parenterally at regular intervals in the early phase of the treatment of acute myocardial infarction, such medication of course accompanying the use of anticoagulants, oxygen, and customary supportive measures. The routine consisted essentially in giving papaverine and phenobarbital orally, or parenterally when vomiting precluded use of the oral route, at four hour intervals around the clock, and 3¾ gr. of aminophylline in 100 cc. of 20 per cent glucose solution by slow intravenous drip at twelve hour intervals. With this regime the disturbing symptoms were adequately controlled in most cases, and it usually became possible to eliminate the midnight and 4 a.m. doses of the drugs after the tenth to fourteenth day. Frequently, however, augmentation of this routine therapy with hypodermic injection of morphine or a morphine substitute had to be made during the first several days.

The undesirable features of this regime were that it required the awakening of the patient for periodic drug administrations through the night and also depended to a considerable extent upon the use of morphine with all its objectionable features. Therefore, in view of Beckman's suggestion in this column (*Wisconsin Medical Journal*, "Comments on Treatment," May 1949) that papaverine be given in rectal suppositories for continuous slow absorption, I modified my regime early in 1951 and treated all acute cases of myocardial infarction subsequently seen by the modified method. The modification consists in eliminating the midnight and 4 a. m. administrations of phenobarbital and papaverine and substituting therefor a papaverine-codeine suppository at bedtime. Throughout the day the oral and parenteral administrations of phenobarbital, papaverine, and aminophylline are continued as before.

The suppository employed contains 6 gr. of papaverine and 1 gr. of codeine incorporated in 2 Gm. of oil of theobroma.

My series of cases is too small to permit statistical analysis, but it is considered worth reporting because all the patients were observed by one clinician in one hospital in which the therapy was administered under standardized conditions. It is my impression that nocturnal distress is strikingly lessened by this new regime. It is nowadays unusual for a patient in my practice to request nocturnal hypodermic administration of morphine or its derivatives after the first 24 hours of the onset of the illness, though they are all informed that such medication is available to them if they wish it. In some cases in which postinfarction angina has persisted for as long as a week after the onset of the occlusion, the use of morphine has not been necessary during the night even when it has been required at frequent intervals throughout the day. In one instance the papaverine suppository was also given twice during the day in an attempt to eliminate the use of sedatives, and the trial appeared successful.

No patient receiving the papaverine-codeine suppository has exhibited evidences of rectal irritation, and no objections have been made to this use of the drug. After the tenth to fourteenth day of illness, the use of the rectal suppository as well as that of the orally and parenterally administered drugs is much reduced and ultimately eliminated during the healing and relatively asymptomatic phase of the episode.

Because of the inherent vagaries in the natural history of myocardial infarction, I have been unable to form an impression of the effect of the suppository use of papaverine on the morbidity or the mortality or the development of arrhythmias in these cases. But it does seem to me to be a fact that patients receiving papaverine suppositories during their first days of myocardial infarction have less chest pain and appear to rest better and have less anxiety than those treated by the earlier exclusively oral method.—MISCHA J. LUSTOK, M.D.

I would go even further than this. Why not introduce a 3 gr. suppository of papaverine (without codeine) every three hours throughout the day and one of 6 to 9 gr. late in the evening? This is certainly not too much papaverine to give by this slow absorbing route, and it may turn the trick entirely. —HARRY BECKMAN, M.D.

Clinicopathologic Conference

Editors—W. A. D. ANDERSON, M. A., M. D., Marquette University School of Medicine, Milwaukee and D. M. ANGEVINE, M. D., University of Wisconsin Medical School, Madison

REPORT OF A CASE*

FIRST ADMISSION.—This 43 year old white male was admitted to Wisconsin General Hospital with the chief complaint of pain in the right knee, which had begun seven years earlier when the right knee had locked in flexion. This had been followed by stiffness and swelling for two months. There had been no further symptoms until one year prior to admission when he had wrenched his right knee again on two occasions. Subsequent to his injury there was swelling, heat, and tenderness of the knee; and finally an operation was done to remove the semilunar cartilage. Following the operation he continued to have heat, pain, and swelling of the knee. Nine months prior to admission the patient had gradual onset of pain, heat, and tenderness in the right ankle and both shoulders. There had been a 30 pound weight loss in nine months.

Physical Examination.—The patient was well developed and fairly well nourished. Blood pressure was 110/65; pulse, 72. The liver was palpable 2 cm. below the right costal margin on deep inspiration. There was marked atrophy of the deltoid muscles with limitation of abduction, flexion, and extension of both shoulder joints. There was marked tenderness of both acromioclavicular joints. There was swelling but no redness of the right knee, with pain on movement, and swelling, tenderness and limitation of motion in both ankle joints. The left thumb had been amputated at the metacarpophalangeal joint. There were minimal Heberden nodes present. The remainder of the physical examination was negative.

Laboratory Studies.—Repeated urinalyses were within normal limits. The hemoglobin content was 11.45 Gm., with red blood cell count 4,840,000 on admission; the hemoglobin content was 7.6 Gm., with 2,840,000 red blood cells three weeks later; and the hemoglobin content was 11.85 Gm., with red blood cell count 5,250,000 ten days after the second count. White blood cell count varied from 4,750 to 16,950, with a normal differential; nonprotein nitrogen level was 28 mg. per cent; blood sugar content 92 mg. per cent; uric acid 4.4, 5.6, 2.7 mg. per cent; prothrombin time 47 per cent, 73 per cent; total proteins 6.6, albumin and globulin ratio 4.2:2.4; thymol turbidity 7 units; Hanger's test negative; and serology negative. X-rays of the right knee, both ankles, and both shoulders showed joint effusion and osteoporosis involving the ankles, right knee, and shoulders, without evidence of actual bone involvement.

Treatment consisted of physiotherapy, nicotinic acid, a trial of colchicine, and salicylates. There was only moderate improvement of the joint symptoms. The patient was discharged on nicotinic acid and iron therapy.

SECOND ADMISSION.—When readmitted two years later, the patient stated that he had continued to have pain, swelling, and limitation of motion of the previously involved joints and also the left wrist and left elbow. Treatment consisted of salicylates and injections of an unknown substance. Two to three weeks before admission, nausea and vomiting at night had developed, accompanied by a burning pain just above and to the right of the umbilicus. The patient had had frequency and nocturia 6 to 8 times at night, dyspnea on exertion, palpitation, dependent edema, and a chronic cough productive of 1 to 2 teaspoonsful of sputum per day.

Physical Examination.—Examination revealed a well developed patient with a partial contracture of the shoulder joints and limitation of motion in the elbow, wrists, and ankles. Blood pressure was 114/68; pulse, 97. There were palpable epitrochlear nodes bilaterally. There was superficial ulceration and crusting of the right side of the nasal septum. The liver was firm and enlarged and palpable 6 to 7 cm. below the right costal margin. The remainder of the physical examination was essentially negative.

Laboratory Findings.—Urinalysis showed a specific gravity of 1.008, with 0.24 per cent albumin, 10 white blood cells, and 1 to 2 red blood cells per high power field. Hemoglobin content was 8.75 Gm., red blood cell count 3,130,000, white blood cell count 12,550, with a normal differential; sedimentation rate 23 mm. per hour; hematocrit index 25 per cent; fasting blood sugar, normal; nonprotein nitrogen 144 mg. per cent; creatinine level of 10.5 mg. per cent; total serum proteins 6.1 Gm., albumin 3.0 Gm., and globulin 3.1 Gm. Addis count showed no casts, 249,830,000 red blood cell count, and 207,500,000 white blood cell count; carbon dioxide-combining power (four days after admission) 17 volumes per cent, and one day later, after strenuous fluid therapy, 37 volumes per cent; serum sodium (five days after admission) was 137 milliequivalents per liter, and chloride was 100 milliequivalents per liter; calcium 6.8 mg. per cent; phosphorus 13.0

*From the State of Wisconsin General Hospital and University of Wisconsin Medical School.

mg. per cent. Urine cultures showed coli aerogenes, Streptococcus fecalis and Staphylococcus aureus; concentration test revealed maximum concentration of 1.013; uric acid 5 mg. per cent; icterus index 4 units; prothrombin time 45 per cent; Hanger's test negative; and thymol turbidity 7.5 units. Phenol sulfonthalein, repeated several times, revealed no excretion of the dye in two hours. Repeated electrocardiogram showed non-specific changes with progressive myocardial involvement. These changes included low voltage, elevation of RS–T_1, RS–T_2, RS–T_3, and RS–T–AVF. A gastrointestinal series showed a duodenal diverticulum. Cholecystogram and chest x-rays were negative. X-rays of the joints showed typical changes of rheumatoid arthritis. On kidney, ureter, and bladder examination, the kidneys were seen and appeared somewhat smaller than the average normal.

Hospital course was that of a progressive renal insufficiency, with the appearance of signs of uremia, including a to-and-fro pericardial friction rub. The patient's blood pressure at all times was within normal limits. Treatment was supportive and consisted of fluid therapy, antibiotic therapy, and one blood transfusion. Three weeks after admission the urinary output, which had been adequate, decreased sharply and there was a progressive fall of the carbon dioxide-combining power with increase in the nonprotein nitrogen. The patient became edematous; rales were heard at the lung bases; and uremic frost was noted on the lips. The course was rapidly downhill, and the patient expired 24 days after admission.

Clinical Discussion

Dr. D. E. Hoff: This protocol concerns a 43 year old white male who died most assuredly in renal failure some three years after his illness first became clinically evident. Until five to six weeks before his death his illness was characterized by a chronic progressive arthritis. The terminal aberration was typical of the uremic syndrome, and the basic problem is to explain, if possible, why chronic arthritis should lead to renal failure, assuming that these two phases of his medical history are related. I will first consider the arthritis, which began when the patient was approximately 42, in a joint previously the seat of trauma. Subsequently both knees, ankles, shoulders, acromioclavicular joints, elbows, and wrists were involved in an ankylosing process. There was associated weight loss and anemia, but among the things we were not told are as follows: the presence or absence of fever; the sedimentation rate; the relationship of leukocyte level to acuity of symptoms and signs; the manner of joint involvement, *i.e.*, the type of onset, assuming the involvement was intermittent; and whether or not there was relationship of symptoms to social factors or dietary indiscretions. Furthermore, we have no knowledge of this man's way of life, his past illnesses, or, for that matter, the physical findings, conceding that a few negatives must be pertinent in this case. Obviously, then, we are at a loss to classify accurately the arthritis on the basis of this protocol. Generally speaking, however, we might say: (1) the course and findings, as known, are consistent with rheumatoid arthritis, and the x-rays are said to support this diagnosis. In the majority of patients with rheumatoid arthritis the hands are sooner or later involved by the process and present a characteristic deformity. This was absent in this particular case. (2) Gouty arthritis might be considered; but the absence of a typical history, assuming that there was none, the persistently normal blood uric acid levels, and the over-all duration of illness in the absence of any of the characteristic features, make this diagnosis unlikely. (3) Gonococcal arthritis, which occurs in approximately 3 per cent of patients with genital gonorrhea, could have been a possibility. The incidence and the severity of the arthritis are independent of the severity of the preceding genital infection, hence the latter may be unrecognized. Anemia is uncommon, although it has been reported. Complete recovery is the usual outcome; however, the joints involved are commonly those enumerated in this case, and gonococcal arthritis, if chronic, will lead to anklyosis and permanent disability. Furthermore, the x-ray picture may simulate that of rheumatoid arthritis.

Now then, why the terminal picture of renal failure and uremia? Again we know literally nothing about the therapy given the patient. At a relatively early stage of his illness the hemoglobin content precipitously fell 33 per cent, and the red blood cell count 41 per cent—this to be followed by a miraculous return to better than initial levels in 10 days. Surely this man was more toxic than the protocol denotes, or there was blood loss with subsequent build-up with transfusions.

There are also other possibilities. Could this be gold or vitamin D intoxication complicating arthritis therapy? Chrysotherapy in current dosages carries with it at least a 25 per cent risk of a toxic reaction, the most common of which are dermatologic, hematologic, and involvement of the gastrointestinal tract. A few cases of acute nephritis have followed its use, and toxic reactions, even severe ones, are unrelated to the stage of therapy, most of the reactions being allergic in type. This man received some type of injections, yet he lacked the more common evidences of toxicity and there was no eosinophilia. Vitamin D intoxication is dependent on demineralization of bone and metastatic calcification. It is the deposition of calcium in the kidney, particularly in the pyramids, that gives the terminal picture. Hypercalcemia and hyperphosphatemia are the rule. In this case we do not have hypercalcemia present; the hyperphosphatemia which is present is more easily explained on the basis of phosphate retention; and the x-rays are not described as showing metastatic calcification or diffuse demineralization.

What, then, is the renal lesion? Certainly the acidosis, the dehydration, the nitrogen retention, symptomatology and pericarditis leave do doubt about the presence of uremia; however, the uremic syndrome has no birthright, so to speak, and is of little help in itself. The statement made, "repeated electrocardiograms show non-specific changes with progressive myocardial involvement," is indeed ambiguous. Did the patient demonstrate electrocardiographic or clinical myocardial changes earlier in his illness; and, if so, what were they? Certainly the electrocardiographic changes described were those of epicardial involvement and were as specific in their concordant pattern as any discordant pattern is with infarct. That they are dependent on subepicardial myocarditis is universally accepted. "The blood pressure at all times was within normal limits." That is, no doubt, weight in influencing the choice of etiology to explain the renal failure. Amyloid disease is said rarely to produce hypertension or eyeground changes, but amyloid disease of the kidney usually presents a nephrotic syndrome rather than these findings of the shrunken kidney. Nevertheless, amyloid disease has been reported in chronic polyarthritis; and in this case we have an otherwise unexplained, large, questionably subnormally functioning liver. It is more likely that this patient had chronic pyelonephritis, as suggested by the Addis count, the low specific gravity of the urine, and the clinical picture. Fully one-fourth of all patients with pyelonephritis are said to have normal blood pressures; and even in those with impairment of renal function, only 50 per cent have hypertension. Pyelonephritis in males is usually due to prostatic obstruction; however, the syndrome of prostatism has multiple etiologies, including urethral stricture, vesicle neck obstruction, and prostatic enlargement.

To explain this protocol on one diagnosis, I must, of necessity, put first chronic gonococcal arthritis, silent urethral obstruction, probably due to an old genital gonorrhea, subsequent pyelonephritis, terminal renal failure, uremia, fibrinous pericarditis, and probably gastrointestinal ulceration. If given a second choice, my diagnosis would be chronic rheumatoid arthritis, with complicating pyelonephritis or amyloid disease.

Dr. D. M. Angevine: Doctor Whitmore, you saw this patient during life. Do you have any comments?

Dr. J. J. Whitmore: The patient was already on the ward when I came on the service. At that time there was a very definite uremia, and no definite diagnosis had been established. We entertained the possibility of a chronic pyelonephritis but were never able to substantiate it to our satisfaction. That was the reason, however, that he was placed on antibiotic therapy. Terminally there was no definite diagnosis, although we had entertained the possibilities that Doctor Hoff suggested.

Dr. R. W. Quinn: We are often fooled by periarteritis nodosa with a clinical picture similar to polyarteritis; and, in view of the kidney lesions I think that it should be considered. I would take exception with Doctor Hoff on the high percentage of toxicity in gold treatment (25 per cent), which seems a bit high. One other thing that we should know about this patient is his occupation. Nothing was said about it in the protocol, and it might give us a lead as to the cause of the kidney lesions.

Doctor Angevine: What did you have in mind?

Doctor Quinn: Well, I'm not sure, but perhaps some form of mercury poisoning.

Doctor Angevine: What was his occupation, Doctor Meyer?

Dr. O. O. Meyer: A crane operator.

Necropsy Findings

Dr. H. J. Van Baaren: In addition to the rheumatoid arthritis there were three different findings. First, there was a severe bilateral pulmonary edema, the left lung weighing 800 Gm. and the right 950 Gm., which probably played a significant role in the death of this patient. In the pericardial cavity were 500 cc. of fluid, while the heart showed an acute fibrinous pericarditis, an excellent example of the so-called cor villosum. However, the most interesting set of findings was a very severe generalized amyloidosis. The liver weighed 2,000 Gm., felt very hard, and on cut section was quite glossy in appearance with loss of architecture, grossly typical of amyloid. We were able to demonstrate the presence of the amyloid grossly by treating the liver with iodine and sulfuric acid, resulting in the bluish

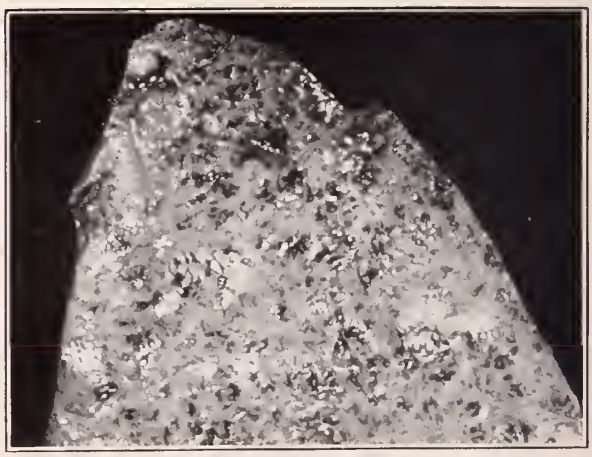

Figure 1.

black discoloration (fig. 1). The spleen weighed only 150 Gm., was extremely firm, and had a gross appearance of amyloid. The kidneys were extremely pale, slightly larger than normal, each weighing 170

Gm. The corticomedullary junction was less distinct than normal.

On microscopic examination, extensive amyloid infiltration of the liver was observed, associated with atrophy of the liver cells. The amyloid material in the spleen was most conspicuous in the malpighian bodies; however, it was diffusely distributed throughout the organ. In the kidney the principal deposition was in the glomeruli. A few scattered collections of amyloid material were observed between the adrenal cords. In frozen sections of liver, spleen, and kidney, stained with gentian violet, the hyaline material stained metachromatically.

Dr. John Huston: The kidneys appear to be slightly smaller than normal. Gas overlying the structure prevents us from telling whether there were calculi. In the sacro-iliac joint there was some indistinctness and probably ankylosis, an early sign of rheumatoid arthritis. The heart was at the upper limits of normal, and there were a few apical pulmonary scars.

Doctor Angevine: We do not have a section of the joints from this case. At the time of autopsy apparently rheumatoid arthritis was not too conspicuous, but undoubtedly it was present, and we will certainly accept the clinical and x-ray evidence as the appropriate diagnosis.

In rheumatoid arthritis, which is a disease of synovial membrane, the initial change is swelling of the synovial membrane, with prominence of the synovial villi; and at the perichondrial junction there is proliferation of connective tissue. In the more advanced cases this fibrous connective tissue grows between the cartilage and causes destruction of the hyaline cartilage. Grossly if one opens such a joint, the synovial membrane is rather thick, the villi are prominent, and there is also an unusually increased amount of fat. In addition, there is a destruction of cartilage, which is secondary to the changes in the synovia. Microscopically one sees large synovial villi with lymphoid tissue resembling lymph follicles. Metachromatic material is seen in the subsynovial tissue when stained with toluidine blue. If treated with hyaluronidase, this metachromatic material disappears.

The type of amyloid described in this case is classified as primary amyloid. Amyloid is usually associated with suppurative conditions, but under certain circumstances, as occasionally in Hodgkin's disease, leukemia, and multiple myeloma, one sees this type of amyloid deposited. It is also seen in malaria, syphilis, and rheumatoid arthritis. It is rather hard to determine the exact incidence in rheumatoid arthritis, but in one series of 61 autopsied cases of rheumatoid arthritis, it was found in 20 per cent of them.[1] It is not known exactly what causes amyloid. From experimental work we know that it can be produced by either injecting or feeding casein to mice. It can be produced by several other proteins. The protein must be a complete protein. It can also be produced by injecting serum into mice and has been observed in horses used for the production of antisera. I had the opportunity at one time to examine the tissues of a large number of immunized horses, and practically all had amyloid in the liver, kidney, and spleen. In this case the amyloid is somewhat atypical. It is considered that this type of amyloid is associated with a hyperglobulinemia, and in such patients there is an inversion of the albumin and globulin ratio. This patient had about 3.2 Gm. of globulin at one time; it may have been higher. Some electrophoretic patterns have been made on such patients, and it has been found that there is an alteration in the globulin, but the studies have not been as extensive in rheumatoid arthritis as they have been in multiple myeloma and some other conditions. As Doctor Hoff has pointed out, in this case there was a low blood pressure which would favor the diagnosis of amyloid disease.

The fibrinous pericarditis, of course, is not related to the rheumatoid arthritis. We consider it to be the result of the uremia.

Dr. S. A. M. Johnson: How many fatal reactions have you seen with Congo Red?

Doctor Angevine: I have seen none.

Doctor Johnson: It came to my attention about a week ago that severe reactions may occur.

Dr. G. G. Rowe: There is a review in the bulletin of the Seaview Hospital[2] where they report a goodly number of cases that died subsequent to the administration of Congo Red. It was always on the second dose of the dye, and the authors thought that it was due to an allergic response. The authors were quite sure that it was the Congo Red which was responsible for the death.

Dr. H. A. Hartmann: Was the heart negative for amyloid?

Doctor Van Baaren: Yes.

Dr. W. S. Middleton: The tongue is also frequently involved.

Doctor Angevine: Yes. However, we did not examine it in this case.

Dr. J. J. Lalich: There has been a report from the Mayo Clinic in which it is stated that the tongue is overly emphasized. In their series the incidence of involvement is only 6 per cent.

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2. Selikoff, I. J., and Bernstein, I. J.: Systemic reactions to the intravenous administration of congo red, Quart. Bull., Sea View Hosp. 8:131–141 (April) 1946.

As It Looks to Your State Board of Health

(These timely discussions of health problems are prepared by staff members as a special service to Wisconsin's physicians.)

The Diagnosis of Chronic Brucellosis

There is probably no better way of introducing this difficult subject than by paraphrasing the remarks of Wesley W. Spink at the symposium on brucellosis held in Bethesda, Maryland, in September 1949. "Much of the confused thinking surrounding the problem of chronic brucellosis can be clarified if available knowledge about the disease is applied intelligently. Enough information is at hand so that some of the confusion can be resolved . . . Because the duration of the natural course of the disease is less than three to six months . . . I . . . called those cases chronic which endure for more than three months, *regardless of the clinical manifestations* . . . The symptomatology of brucellosis is not specific for that disease only. Briefly, the clinical manifestations are weakness, easy fatigability, sweats, headaches, generalized aches and pains, mental depression, nervousness, sexual impotence, anorexia, and constipation . . . Hundreds of functionally disordered patients haunt the offices of physicians every day presenting the complaints . . . just listed. Many times sincere and conscientious doctors attempt to resolve the functional complaints (of neurasthenic and psychoneurotic patients) on an organic basis and make a diagnosis of chronic brucellosis if a positive intradermal test with Brucella antigen is obtained. These tense and neurotic patients then use brucellosis as a crutch . . . A patient with undoubted brucellosis (on the other hand) may have been erroneously labeled as a psychoneurotic, although this mistake occurs less frequently than the reverse."

It is apparent that the chronic phase of brucellosis cannot be expected to yield itself to ready clinical recognition. This tends to make the physician more dependent upon laboratory tests as an aid for the establishment of a diagnosis of this disease; but as with all laboratory work (and probably more so in the case of brucellosis) clinical judgment is of paramount importance in evaluating and correlating the laboratory findings with the clinical picture. In view of the non-specific nature of the symptomatology in the chronic phase of brucellosis, an understanding of the significance and limitations of the bacteriologic and immunologic studies which may be available becomes a factor of major importance.

The successful cultural isolation of the organism from the blood or other body fluids, or from the tissues, unquestionably establishes the diagnosis of brucellosis. However, the frequent failure of multiple efforts in acute cases, where daily culture for at least seven to ten days is recommended for reasonable assurance of successful isolation, makes such study in chronic cases (where septicemia is frequently absent, or at best, intermittent) highly impracticable for reliable routine use. Several failures to obtain successful cultural isolation in a chronic case far from precludes reasonable entertainment of a diagnosis.

The physician must resort to other diagnostic aids. Since the Brucellergen skin test is merely an indication of previous infective exposure to the organisms rather than an index of infective disease activity (very much as in the tuberculin or Mantoux test), and since previous surveys have shown positive reactions in from 20 to 40 per cent of healthy rural population groups, the intradermal test must be considered as of little or no diagnostic value. This impression is reinforced by the occasional, though rare, finding of a culturally-positive Brucellergen-negative case due to anergy. The intradermal test, moreover, frequently results in sufficient agglutinin production (even when negative) to yield significant agglutination titers for many months. In general, the test should be considered of highly questionable value as a diagnostic aid in chronic brucellosis.

The agglutination test is by far the most useful for routine purposes, but a proper understanding of its limitations is essential for intelligent interpretation by the physician. A single sample may range in reports from different laboratories from negative to as high as 1/1280. This may be attributed to several factors. First, a great variation exists among different laboratories in the performance of the test. Second, incubation periods for the reading of a complete agglutination may vary in different laboratories from 24 to 48 hours. Again, the use of varied antigens without adequate standardization may account for much of the difficulty.

In general, an agglutination titer of 1 to 80 or above, accompanied by an appropriate history and clinical findings, may be considered diagnostic. For practical purposes the physician in Wisconsin need not concern himself about cross-reactions. Tularemia, in a few cases, may yield significant titers, but the clinical picture should rule it out. Asiatic cholera vaccination may produce significant titers for as long as three years and may be a factor found in returning war veterans.

Where a patient with chronic complaints has a low agglutination titer, repeated specimens showing fluctuating titers may be of value in indicating active infection.

The opsonocytophagic reaction is a tool of highly controversial value, yields highly inconsistent results with various workers, and requires prompt determination with fresh blood, a smooth culture of virulent antigen, and positive and negative controls. The index has no parellelism with disease activity, and when high and accompanied by a negative agglutination it may be considered a measure of the immunity status of the patient.

Bactericidal tests hold promise of future usefulness in the determination of activity, but are, as yet, routinely unavailable to the physician. The sedimentation rate is very variable in both the acute and chronic phases of brucellosis and is of no value in the determination of activity. Nor is the blood picture of any significant value in either phase of the disease. In view of the broad range of bacterial and viral effectiveness of aureomycin and chloromycetin, certainly no diagnosis can be established by a patient's response to such therapy.—MILTON FEIG, M.D., M.P.H., *Director, Section on Preventable Diseases.*

ANNOUNCEMENT OF REGULAR CORPS EXAMINATION FOR MEDICAL OFFICERS

United States Public Health Service

A competitive examination for appointment of Medical Officers to the Regular Corps of the United States Public Health Service will be held on June 3, 4, and 5, 1952. Examinations will be held at a number of points throughout the United States, located as centrally as possible in relation to the homes of candidates. Applications must be received *no later than April 30, 1952.*

The Regular Corps is a commissioned officer corps composed of members of various medical and scientific professions, appointed in appropriate categories such as medicine, dentistry, nursing, engineering, pharmacy, etc.

Appointments will be made in the grades of Assistant Surgeon (equivalent to Navy rank of Lieutenant (j.g.) and Senior Assistant Surgeon (equivalent to Lieutenant). In making assignments, consideration is given to the officer's preference, ability, and experience; however, all commissioned officers are subject to change of station and assignment as necessitated by the needs of the Service. Appointments are permanent in nature and provide opportunities to qualified physicians for a life career in clinical medicine, research, and public health. Applicants who successfully complete this examination may ordinarily expect appointment as soon as they become eligible.

Requirements:

Both grades: United States citizenship. At least 21 years of age. Graduation from a recognized school of medicine.

Assistant Surgeon: At least seven years of educational training and professional experience subsequent to high school.

Senior Assistant Surgeon: At least ten years of educational training and professional experience subsequent to high school.

Applicants who meet these qualifications within nine months of the date of the written examination will be admitted, but may not be appointed until they fulfill the requirements. Physicians who are successful in the examination and are now serving internships will not be placed on active duty in the Regular Corps until completion of internship. The examination will include an oral interview, physical examination, and written objective tests covering the professional field.

The written professional examination for the grade of Assistant Surgeon covers the following material: basic medical sciences, including anatomy, physiology, biochemistry, microbiology, and pathology; practice of medicine, including internal medicine (including neurology and psychiatry), therapeutics and toxicology, pediatrics, and medical problems of obstetrics and gynecology; practice of surgery, including surgery, orthopedics, gynecology, obstetric procedures; and preventive medicine and public health. The examination for Senior Assistant Surgeon will include the above subjects with the exception of anatomy.

Physical Requirements: Candidates must be found physically qualified as a result of an examination performed at a Public Health Service facility. The physical standards for appointment to the Commissioned Corps are relatively high. Candidates who have a physical defect, or who have had serious illness or injury, should attach a statement to their applications outlining in detail the nature of such illnesses or injuries, treatment received, periods of hospitalization, length of absence from work, and present status.

Application forms and additional information may be obtained by writing to the Surgeon General, United States Public Health Service, Federal Security Agency, Washington 25, D. C. Attention: Division of Commissioned Officers.

Facts about

Blue Shield of Wisconsin

an agency of the State Medical Society of Wisconsin

Prepared by the Directing Board of Blue Shield of Wisconsin, an Agency of the State Medical Society of Wisconsin, E. M. Dessloch, Prairie du Chien, Chairman.

Income Limits and "Full Payment"

Because Wisconsin Physicians Service is a service program within certain income limits, participating physicians have the problem of considering the Blue Shield subscriber's income to know whether the benefit paid by Wisconsin Physicians Service is to be considered "full payment."

This is not a problem peculiar to Blue Shield patients. It is a responsibility that most physicians have in adjusting their fees to the ability of the person to pay. In the case of Blue Shield patients, the matter is simply more clearly defined—for example, the Blue Shield benefit is considered full payment for usual services to members of a family whose income is less than $3,600 a year.

How is Income Defined?

Income is the total wages, salary, or other compensation of the subscriber, his or her spouse, and all other dependents, for the 12 months preceding the date on which services are first requested or provided, plus any other income of these persons includable in their federal income tax returns, except capital gains or losses.

The word "dependents" as used in that definition means the husband or wife of a subscriber, and all unmarried children principally supported by the subscriber, under 19 years of age. It also means dependents who are eligible to enroll in the program whether enrolled or not.

EXAMPLE: A family of four has Blue Shield protection. The husband earns $2,400 a year. The 14-year-old daughter earns $200 at odd jobs. The 18-year-old son living at home earns $2,000 a year at a full-time job. What is the "income" of this family under the Blue Shield definition?

ANSWER: The family is over the $3,600 income limit and full payment provision does not apply. The daughter's income does count since it is reportable on federal income tax returns. The son's income is included because he is classed as a dependent until his nineteenth birthday.

Does the Definition Mean "Gross Income?"

Gross income is *not* the proper term for the income on which the physician should base his fees under Blue Shield. It is *not* the income which affects the "full payment" provision of the contract.

Farm family income is a good illustration of this situation:

Farmer Brown has a total income from all sources of $10,000. His operating expenses, deductible on federal income tax returns, total $7,000. If there is no other income, the physician must consider Farmer Brown's income for Blue Shield purposes at $3,000.

Business and professional men present the same situation. Such a person's so-called "gross income" represents total income before deduction of allowable operating expenses.

It might fairly be said that "income" as used in Blue Shield contracts is net income, before personal exemptions, and excluding capital gains or losses. However, the contract definition is phrased broadly enough to include everything that is "income" under the federal law, and any attempt to be too specific tends to confuse both physicians and the public.

What Constitutes "Income" for Farm Workers?

Question may be raised as to how a physician should compute the income of a farm or other worker who receives part of his income in wages and the remainder in room and board or house rent. Two examples are presented:

A. A single hired hand receives $100 a month plus room and board. It is difficult to generalize, but advice would indicate that a physician may fairly estimate the "reasonable cash value" of room and board. This may vary from farm to farm, but probably might range from $10 to $15 per week.

B. A married farm worker receives $170 a month plus house rent. Value of house rent would depend upon the type and condition of the house and the going rentals of a particular area. Local inquiry would help the physician ascertain his policy in this respect.

The determination of income, whether as a private-pay patient or a Blue Shield subscriber, is a matter to be resolved by the physician and the subscriber. Physicians should realize that, for patients but slightly over the income levels, they should be guided by the spirit of the plan in deciding whether or not an additional fee should be charged.

The State Medical Society has devised a "Statement of Income" form which you may obtain upon request. This form may be presented to patients when they first request service. It asks two questions about a person's income during the previous 12 months:

1. My income as a single person WITHOUT dependents was _____.
2. My income PLUS dependents' income was _____.

Physicians desiring to use this form as an aid to handling financial arrangements with patients are urged to write the State Medical Society specifying the quantity of forms desired.

THE MEDICAL FORUM

MEDICAL-PRESS CONFERENCES TO START IN SHEBOYGAN

First Meeting to Be Held April 24; Nine Others Scheduled Before July

Madison, Mar. 1.—A new approach to medical and hospital relationships with newspapers and radio stations in Wisconsin will be inaugurated on April 24 with the first of a series of Medical–Press Conferences sponsored by county medical societies in cooperation with the State Medical Society.

The first meeting will be held at the Grand Hotel in Sheboygan under the sponsorship of the Calumet, Manitowoc, Sheboygan and Washington–Ozaukee county medical societies.

The conferences are called to help the working press in its job of gathering and presenting medical news and to help physicians understand the needs and problems of publishers and radio broadcasters.

At the same time, the meeting is expected to be an opportunity for members of the press to learn about the responsibilities of physicians and hospitals for their patients and the problems involved in presenting medical news.

Conferences are scheduled at Sheboygan, April 24; Madison, May 1; Milwaukee, May 15, and Appleton, May 22. Other meetings are planned for Wausau, La Crosse, Superior, Lancaster and Rice Lake.

Invitations will be sent to all newspapers, radio stations, hospitals and physicians. Sheriffs, police officers and fire department chiefs may also attend.

The program includes brief talks by a physician and a newspaper or radio representative. Most of the session will be devoted to open forum discussion.

The conferences have been developed by the Council on Medical Service of the State Medical Society as part of an expanded public relations and physician relations program. Dr. C. G. Reznichek, Madison, is in charge of the arrangements for the series of meetings.

Emergency Call Systems Making Rapid Progress

Chicago, Feb. 6—Rapid strides are being made in the development of emergency call systems for physicians.

A recent report by the A.M.A. Council on Medical Service shows that more than 350 medical societies reported a formal plan for handling emergency and night calls in 1950. Only 60 societies made a similar report in 1948.

There is still need for more work on the problem, however, especially among the smaller medical societies, the AMA stated.

Baraboo Designated Critical Defense Area

Becomes Eligible for Federal Aid for Health Facilities

Washington, D. C., Feb. 10.—The Baraboo housing area has been declared a "critical defense area" eligible for federal assistance in the construction and maintenance of defense housing and community facilities, including such things as hospitals and other places for the care of the sick.

The area includes "Sauk County; and the towns of Arlington, Caledonia, Dekorra, Fort Winnebago, Lewiston, Lodi, Newport, West Point, Pacific and the cities of Lodi, Portage and Wisconsin Dells and the village of Poynette, in Columbia County; Wisconsin."

In the case of construction of hospitals or other places for the care of the sick, application to the Hill–Burton funds must first be made and refused before assistance may be given under this law.

The federal government may make loans to public or nonprofit agencies if the local community is unable or unwilling to carry out its responsibilities.

Under certain conditions the federal government might actually operate hospitals and other health facilities financed by funds under this law.

Co-op Offers Medical Scholarships

St. Paul, Feb. 25.—Two medical scholarships of $500 a year will be awarded this spring by Group Health Association, St. Paul.

The awards will go to applicants planning to enter the field of medicine as physicians, nurses, administrators or technicians. Candidates will be judged on the basis of scholarship, character, understanding of cooperative principles and the personnel needs of the cooperative health movement.

Financed by Levy

The scholarships are made possible by a fund created from an annual 10-cent per member "contribution" from Group Health members.

Last year the scholarships went to a medical student and a nursing student from the University of Minnesota.

"Too Many Specialists" Gripe is 3,500 Years Old

Madison, Feb. 15.—The Milwaukee Journal of Jan. 17 carried the following article entitled "Too Many Specialists in Medical Profession:

More than 4,000 years ago, the Babylonian king Hammurabi established socialized medicine and fixed the fees of physicians according to the means of the patient.

In 1500 B.C., the citizens of Thebes were complaining that there were no longer any good old family physicians. Every one was a specialist. "The practice of medicine," writes Herodotus, the Greek historian, "is so divided among them that each physician is a healer of one disease and no more. All the country is full of physicians, some of the eye, some of the teeth, some of what pertains to the belly."

Fond du Lac Auxiliary Boosts Medical Public Relations with "Reminder" Card

Fond du Lac, Feb. 10.—Widespread local distribution of a card listing health services in Fond du Lac is making medical public relations history in Wisconsin.

The Woman's Auxiliary to the Fond du Lac County Medical Society has prepared a four by six inch card on which are listed the telephone numbers of the major health services available in that city.

The card is being widely circulated through doctor's offices, drug stores and civic clubs. It may be attached to telephone books or hung in a convenient location in the home.

Most important, the card points out that emergency medical services can be obtained through the Fond du Lac Physician's Exchange, Phone 8886.

Other telephones listed are the hospital, nurse's registry, visiting nurse association, and the city, county and district health office.

Card holders are also urged to listen to the "March of Medicine" the radio program which is broadcast weekly by KFIZ under the sponsorship of the State Medical Society.

NAM Urges Voluntary Aid to Medical Schools

New York, Feb. 15—"Business enterprises must find a way to support the whole educational program effectively, regularly—and *now*."

With this resolution, the National Association of Manufacturers has launched an unprecedented, nation-wide campaign to get businessmen to come to the financial aid of America's public and private schools.

In letters to more than 17,000 members of the association, each was asked to take the lead in a drive to aid public and private schools, with particular concern for medical and technical schools.

The association has taken this action because influential leaders in business and industry are concerned over the "freeze" in funds available for education at the very time when educational needs are expanding and costs mounting rapidly.

Distinguished Service!

Eulogy offered up by the *Pomeroy*, Ohio, *Democrat:* "For 59 years he practiced medicine, being responsible for most of the babies born in this community."

Reproduced from Editor & Publisher, Feb. 2, 1952.

Doctors Urged to Take Public Relations Lessons from Industry

Detroit, Feb. 17.—A plea that the medical profession mend its public relations fences before it becomes as vulnerable to public mistrust as industry, was voiced here today by an industrialist.

Speaking at the annual county secretaries' public relations conference of the Michigan State Medical Association, Fred A. Kaiser, vice-president of the Detroit–Michigan Stove Co., warned the state's doctors that they have been remiss in their public relations job.

Three Problems

"We businessmen have been under fire much longer than you have," he explained, "so you have a great opportunity to gain by our experience in counteracting the influences which are working against you."

"A fight such as yours can never be finished. It requires constant attention to good public relations to build confidence in the profession in the minds of the public."

He urged doctors to give serious thought to three "points of aggravation:"

1. Unwillingness of the average doctor to make a house call.

2. Failure by doctors to meet schedules of office appointments, primarily due to poor scheduling either by the doctor or his office assistant.

3. Over-specialization.

Mr. Kaiser recounted Detroit's ill-fated adventure into socialism through muncipal ownership of its transportation system as an answer to those who advocate socialized medicine.

Warren for President —AND Compulsory Health Insurance

Chicago, Feb. 15.—Governor Earl Warren of California, now a declared candidate for the Republican nomination for President, has renewed his advocacy for compulsory health insurance.

In recent speeches he denied that he is in favor of "socialized medicine", but believes that **"it is the responsibility of the states to undertake to help doctors, hospitals and the public they serve"** to make it possible for **"every one of our people to protect himself and his family from the economic disaster of backbreaking hospital and medical bills."**

Dr. John Cline, San Francisco, President of the American Medical Association, issued a warning "Governor Warren, in common with President Truman and Federal Security Administrator Ewing, repudiates the term socialized medicine while warmly embracing the substance."

Warren has been defeated several times in his attempts to secure enactment of a compulsory health insurance plan for California. Dr. Cline pointed out that over 3,000,000 Californians are now enrolled in voluntary prepaid plans —more than Warren promised to cover under his compulsory scheme.

$500,000 for Medical Needs in Civil Defense

Madison, Jan. 22.—Wisconsin civil defense officials have estimated that a total of $507,707 will be needed to provide adequate civil defense medical stockpiling for this state.

This includes the cost of training and operating about 100 mobile medical teams as part of civil defense battalions. Included in the amount is $260,000 for dried plasma, and varying amounts for litter-cots, drugs, medical equipment, radiological monitoring supplies, etc.

State civil defense officials have submitted a plan to the Federal Civil Defense Administration which, if approved, will result in the Federal government assuming 50% of the cost of medical stockpiling for Wisconsin.

Farm Bureau Puts "Wisconsin Plan" Insurance Into 6,000 Farms in Year

Madison, Feb. 15.—The Wisconsin Farm Bureau Federation is using its rural mutual casualty insurance system to spread prepaid hospital and surgical care among farmers.

The federation sells the "Wisconsin Plan" as approved by the State Medical Society. It has put the plan into effect on more than 6,000 farms since October 1950.

"We started cautiously," says L. A. Roherty, Madison, director of insurance in the Farm Bureau headquarters. "The policies are open only to farm families who are members of the Farm Bureau. We are confident that we will double the number of participants because the farmer is so conscious of the cost of hospital care."

"In time we think most Wisconsin farmers are going to have prepaid protection," Roherty declares. "They need it because farming has become one of the more hazardous occupations. Besides, the farmer is entitled to better health and medical care than he has had."

Roherty also indicated that the Farm Bureau is interested in doing something to get more physicians and dentists into rural areas.

Hospital Addition Honors Dr. Senn

Milwaukee, Feb. 10—The new addition to Milwaukee Hospital, dedicated on Feb. 10, was named for a physician who began his career as a school teacher, and ultimately became an internationally known surgeon.

He was Dr. Nicholas Senn, one of Milwaukee Hospital's first chiefs of staff.

Born in Switzerland in 1844, Dr. Senn became a school teacher at 18, and two years later began the study of medicine at Chicago Medical College. He began his practice in Elmore, in the southeastern corner of Fond du Lac County.

He became chief of staff at Milwaukee Hospital in 1874, later going to Rush Medical College, where his surgical clinic became one of the largest and most famous in the world.

The Senn addition to Milwaukee Hospital houses 30 patient beds, new x-ray and physical therapy equipment and outpatient departments.

Small Town Students Make Small Town M.D.s, AMA Survey Shows

Chicago, February 12.—An increase in medical school enrollment of students from smaller towns would probably result in a larger supply of doctors in such areas, according to Dr. H. G. Weiskotten, chairman of the Council on Medical Education and Hospitals of the American Medical Association.

Speaking at the annual Congress on Medical Education and Licensure, Dr. Weiskotten based his opinion on findings of a study of the present location of physicians who graduated from medical school in 1930, 1935 and 1940.

He found that 46 per cent of the graduates who lived in communities of 2,500 to 10,000 population before they attended medical school returned to areas of the same size. Nearly 30 per cent of those whose homes were in towns of less than 2,500 went back to the same sized community.

It was also apparent from his study that students tended to practice in the same state in which they attended medical school, and took their internship or residency.

Citing the shortage of medical men in small towns, he urged medical schools to recruit more students from rural areas.

Hospitals Advised to Take No Priority I Physicians as Residents

Madison, Feb. 12—All Wisconsin hospitals are advised to select no residents for 1952–53 from Priority I Selective Service registrants "**except under very exceptional circumstances, and probably in no instance except where there is a question of servicing an isolated community hospital.**"

This is the advice of the National Advisory Committee to Selective Service to the Wisconsin Advisory Committee, according to Dr. F. L. Weston, chairman.

All hospitals are urged to select their residents in the reverse order of their priority under the doctor-draft law.

FSA to Quiz Social Security Recipients

Chicago, Feb. 15.—The Federal Security Agency is planning to quiz beneficiaries of social security and old age assistance, according to Dr. George F. Lull, secretary and general manager of the A.M.A.

He reported that an eight-page questionnaire has been prepared to find out how often the beneficiary or a member of a family has been ill during the past year, both at home and in the hospital.

It is believed the questionnaire survey is being launched for the purpose of preparing propaganda to increase payments to beneficiaries and support Oscar Ewing's plans for "free hospitalization" for those over 65.

CLAIM BLANKS

A Wisconsin doctor is likely to handle more TIME claim blanks than any other company's. TIME, a leader in the accident and health insurance field, insures a large portion of the total number of persons carrying such insurance in Wisconsin.

Few doctors appreciate the great service given to their patients when these claim forms are handled promptly.

Any suggestions from you as to how our claim forms may be improved will certainly be appreciated.

• • •

The Time Insurance Company

215 WEST WISCONSIN AVENUE

Milwaukee 3, Wis

Harry Becker, Federal Medicine Advocate, Helps Direct Hospital–Medical Care Study

Washington, D. C., Mar. 2.—Harry Becker has been granted leave from his position as Welfare Director of the United Auto Workers, (CIO) to be associate director of the Commission on Financing of Hospital Care.

The Commission is sponsored by the American Hospital Association to evaluate the current financial position of hospitals, determine the need and demand for hospital services, analyze the effect of medical practice on hospital costs, establish means for obtaining high quality hospital service at the lowest possible costs, and to evaluate systems of payment for hospital care.

Harry Becker has long been one of the nation's most militant advocates of government controlled medical and hospital care. He, along with Walter Reuther, President of the UAW–CIO, proposed a plan three years ago to provide federal subsidization of hospitals and hospital insurance premiums.

Director of the commission is Graham L. Davis, former president of the American Hospital Association. Chairman of the commission is Gordon Gray, former secretary of the Army, and now president of the University of North Carolina.

NORTH HAS 61% OF OLDER GROUP

New York, Mar. 1.—More than 10 per cent of the people in six states, all in the North, are now 65 years old and over, according to figures compiled by the U. S. Bureau of the Census and released by the Institute of Life Insurance.

When the census of 1940 was taken, no states had as much as 10 per cent of their population in this age group.

New Hampshire and Missouri have the largest proportion of persons 65 and over. New York is the only state with more than a million persons in this age bracket.

Sixty-one per cent, or 7½ million aged persons, live in the northern states. The "retirement" states—Arizona, Florida and California—have rapidly gained on the northern states during the last decade, however.

PAT AND MIKE STOP TREATING

Horses and Men Are Worse Off for Retirement of Brothers

The Milwaukee Journal of January 6, 1951, ran the following story on the careers of the Wilkinson brothers of Oconomowoc:

Oconomowoc, Wis.—A chapter ended recently in Oconomowoc's "Pat and Mike" story.

Pat is Dr. Patrick J. Wilkinson, a veterinary surgeon. Mike is Pat's brother, Dr. Michael R. Wilkinson founder of the Wilkinson clinic here.

The brothers breezed into town before the turn of the century, Pat with his veterinarian's sign and Mike with his medical diploma. Together they cared for beast and man, respectively, for half a century.

Early in 1951 Mike was forced to retire because of ill health. Last week Pat put his veterinarian equipment up for sale. Pat had settled here "temporarily" 57 years ago. He started out as a horseshoer in Milwaukee and attended the Chicago Veterinary college, graduating at the top of his class.

Pat's favorite work was pulling teeth. He started saving them and now there's a small mountain of them piled in his back yard. His sign originally read "Veterinarian and Dentist," but he received too many calls from two legged animals, so he changed his sign.

In his many years of practice, Pat has played nursemaid to animals ranging from minks to mules. He says the easiest animals to get along with are horses.

Military Gets 1,000,000 Pints of Red Cross Blood

Washington, D. C., Mar. 10.—The American National Red Cross has announced that it has collected and turned over to the military forces 1,225,000 pints of blood since the start of the Korean War 18 months ago.

About 160,000 pints were shipped to the Far East as whole blood, the rest was processed into plasma. During the same period, Red Cross collected and processed 1,861,000 pints for civilian use.

10 WAYS TO KILL A MEDICAL SOCIETY

Boston, Oct. 16.—The Massachusetts Medical Society's News Letter lifted an item from the September News Letter of the American Society of Anesthesiologists. The Medical Forum, in turn, lifts it from Massachusetts:

Ten Ways to Kill an Association

1. **Don't come to the meetings.**
2. **If you do, come late.**
3. **If the weather doesn't suit you, don't think of coming.**
4. **If you do not attend a meeting, find fault with the officers and members.**
5. **Never accept an office, as it is easier to criticize than do things.**
6. **Nevertheless, get annoyed if you are not appointed to a committee. If you are appointed, don't attend the committee meetings.**
7. **If asked by the Chairman to give your opinion regarding some important matter, tell him you have nothing to say. After the meeting tell everyone how things should have been done.**
8. **Do nothing more than is absolutely necessary. When other members roll up their sleeves and unselfishly use their ability to help things along, howl that the Association is run by a "clique".**
9. **Hold back your dues as long as possible—better still don't pay at all.**
10. **Don't bother about getting new members, but if you do, be sure they are grouches like yourself. (Age Publications Ltd., Toronto)**

"Third Parties" to Pay Most Hospital Bills 10 Years Hence

Milwaukee, Feb. 14.—The prediction that almost all hospital income ten years from now will come from third party payments made by Blue Cross or private insurance carriers was voiced at the Wisconsin Hospital Association annual meeting on Feb. 14.

Harry Becker, Chicago, former director of the social security department of the UAW-CIO and now associate director of the Commission of Financing of Hospital Care, told the group that "it is reasonable to assume that in the next decade we may almost double the number of persons who have prepaid hospital care and, at the same time, bring the level of protection to a point where the full hospital bill is paid under prepaid arrangements."

Six Member Panel

He was a member of a panel including George H. Hipp, Wausau, manager of the group department of Employers' Mutual Insurance Co.; Leon R. Wheeler, Milwaukee, executive director of Wisconsin Blue Cross; John W. Tramburg, Madison, director of the state department of public welfare; A. J. Thelen, Madison, executive secretary of the Wisconsin County Boards Association, and Franklin Carr, Waukesha, president of the Wisconsin Hospital Association.

High Costs, More Services

Mr. Becker contended that "it is not possible to expand standards of care, provide services to more people and still meet higher costs of operation, at the same time, asking the consumer of hospital services for more money."

Mr. Hipp Replies

Mr. Becker urged more full coverage and "necessary arrangements" to care for the aged, chronically ill and the non-wage earner.

Mr. Becker urged hospital administrators and boards to have no part of commercial insurance carriers. He said "the evidence is clear" that they "are not going to be able, on a cash indemnity basis which pays less than the cost of care, to perform the job which is required for a sound community program for financing and developing hospital services."

Mr. Hipp replied that insurance companies have demonstrated through their cooperation with the State Medical Society that "full payment" is workable among private carriers. He said insurance firms could not write full coverage until hospitals could predict accurately what future costs will be.

Cost Accounting Needed

Hospitals are badly in need of uniform cost accounting systems, Mr. Hipp stated. In addition, he criticized the policy of some hospitals giving discounts to patients with certain types of prepaid care plans.

Mr. Hipp asked for cooperation between hospitals, insurance companies and Blue Cross to solve the problem of increasing hospital care costs.

Western States Combine Aid to Medical Education

Chicago, February 11.—Eleven western states and two territories are combining to provide aid to higher education in the fields of medicine, dentistry, public health and veterinary medicine.

Colorado, Montana, New Mexico, Utah, Oregon, Arizona, California, Idaho, Nevada, Washington and Wyoming, and the territories of Alaska and Hawaii, most of whom have approved the plan, will pool their finances to provide capital and professional educational services and to assist in the placement of students.

Humane Society Agrees to Stay Within the Law

Chicago, Mar. 1.—"We congratulate the Wisconsin Humane Society for throwing off the shackles of antivivisectionist domination."

Those are the closing words of an editorial in the January–February issue of the *Bulletin* of the National Society for Medical Research.

The editorial referred to the recent action of the Wisconsin Humane Society in asking the Milwaukee county board to renew its dog pound contract.

Last September the humane society had announced it would not operate the pound under the Wisconsin law requiring that dogs needed for medical tests be withheld from destruction at public pounds.

Controversy split the humane society for several months, and when the issue was resolved in favor of continuing assistance to stray animals, three of the humane society's directors and the society's paid director resigned, according to the *Bulletin*.

In announcing the new policy, the humane society said: "whether or not it agrees with the legislation, the humane society is interested in seeing that stray dogs are handled in the most humane way possible," the *Bulletin* reported.

Most Interesting Comparisons Column

266 words—Gettysburg Address
300 words—Declaration of Independence
26,911 words—OPS order reducing the price of cabbage.

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"WHAT DO YOU GET FOR YOUR $25 AMA DUES?"

By W. W. BAUER, M.D.

This article is a reprint of an address delivered by Dr. W. W. Bauer, director of the AMA Bureau of Health Education, at a recent meeting of the Medical Society of the State of Pennsylvania in Pittsburgh. It is reprinted with the permission of Dr. Bauer and the AMA.

When you send that check to your local medical society, including state dues and, more recently, A.M.A. dues, the thought may flash across your mind—what am I getting out of this?

The immediate and obvious answers are that you are getting status as a reputable physician accepted by your professional colleagues plus recognition of your right to mingle with them professionally and participate in their discussions and work with them for common objectives. You are getting a place in a great team of almost 150,000 members dedicated to "the advancement of the science and art of medicine and the betterment of the public health."

That little membership card entitles you also to a great many other services, some direct, many indirect. Some years ago the late Dr. Rock Sleyster, President of the A.M.A., characterized the Association headquarters as an ammunition factory where products are developed for use on the battle lines. Some of these products are as tangible as a pamphlet and others, equally important, as intangible as an attitude.

You are all well acquainted with the routine membership privileges such as attendance at meetings with participation, eligibility for committees and offices, and the right to be heard in any meeting of physicians. I will spend no time dwelling on these but proceed at once to some of the services available to you of which you must be unaware, because you utilize them so seldom.

The Judicial Council furnishes a court of last resort to decide ethical questions under the general policies laid down by the House of Delegates, thus giving the individual physician the strength inherent in group support for his ethical standards which are often at variance with the ideas of less altruistic individuals.

The evaluation of new drug products through the Council on Pharmacy and Chemistry is a service which affects every practicing physician. He can make direct use of it by using and encouraging the use of accepted products, but whether he does so or not, the whole level of production and introduction of new drugs is raised by the very existence of the Council and the knowledge among manufacturers that whatever new drug product they offer to the profession will be closely scrutinized and evaluated without fear or favor.

In like manner the Council on Foods and Nutrition tends to improve the quality and regulate the claims for foods having medicinal significance, while the Council on Physical Medicine and Rehabilitation performs a similar function in its field.

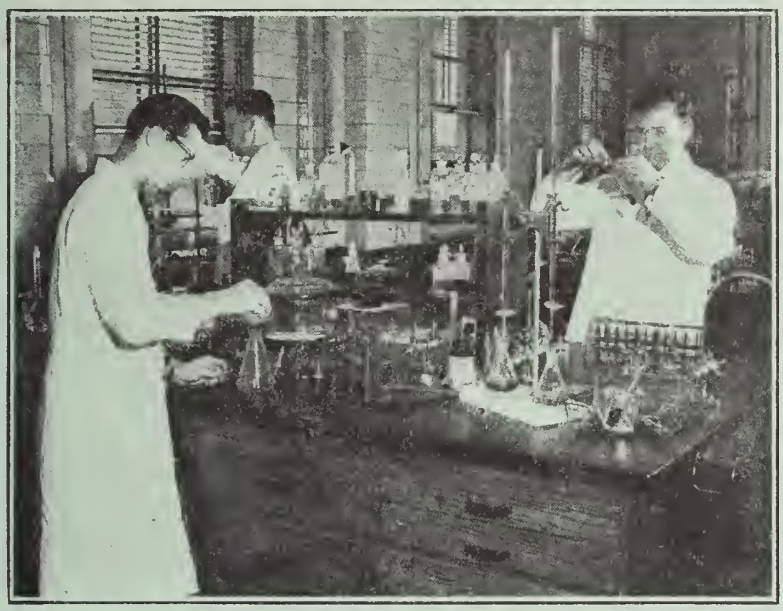
The evaluation of medical schools and hospitals through the Council on Medical Education and Hospitals is known to every physician. So is the work of the Bureau of Legal Medicine and

DR. W. W. BAUER

Legislation, whose name defines its functions and whose reports in the JOURNAL and subsequent assembling in volumes of reports and decisions have served physicians for many years.

Well known also is the Council on Scientific Assembly and the closely related Committee on the Scientific Exhibit through which the world's greatest medical meetings are made available to phy-

535 NORTH DEARBORN ST., CHICAGO—The home of the American Medical Association houses more than 800 employees; offices for nearly 50 councils, committees, bureaus and departments; a complete printing plant; an extensive medical library; a radio recording studio and a film projection room.



A FULLY-EQUIPPED CHEMICAL LABORATORY in the AMA headquarters serves the profession and the public under the direction of the Council on Pharmacy and Chemistry. Its director is Dr. Robert T. Stormont, formerly of La Crosse, Wis.

sicians twice a year, once in the form of the Annual Session, and once on a more regional basis through the Clinical Session, held in midwinter.

Of course, the JOURNAL of the American Medical Association and the nine specialty journals require no introduction to the doctor. When he considers his $25 investment, the JOURNAL or his alternate choice of one of the special journals would in itself fully compensate him, considering the prices of other publications and the intrinsic value of his own organizational press. Everything over and above these can be regarded as extra dividends.

Nothing to Sell

If your state medical journal is a member of the State Journal Advertising Bureau, you get consultation and sales service on advertising contracts which have made possible large increases in revenue and savings in sales costs, and have opened the pages of state journals to advertising which might otherwise not have been available.

Dr. Olin West once related the story of a doctor who came into his office to complain about the increase of A.M.A. fellowship dues from $6 to $8. Doctor West, who had known his visitor for many years, listened to his complaint and then engaged him in casual conversation and finally asked him how his golf game was. The doctor admitted that it was excellent and then Doctor West asked him where he played, whereupon he named three or four clubs in the Chicago area. Doctor West commented that this must be rather expensive to which the doctor replied that his total dues did not exceed a few hundred dollars a year. Doctor West then reverted gently to the original topic and source of complaint, a $2 increase in fellowship dues.

In these days of high and spiraling prices, the A.M.A. must buy materials and services in a rising market. Printing materials and office supplies are increasingly expensive and so are labor and clerical costs and travel. It is necessary in such a situation either to curtail services or to meet the cost by developing increased income. The A.M.A. has nothing to sell to the public and therefore cannot increase commodity prices. Its only source of income is the advertising revenue of its publications and the dues of its members.

The Association has taken special pride in its independence of government funds, foundation grants, and other income whose acceptance might impair the complete freedom of the Association to determine its policy and voice its opinions. The profession must pay a price for these privileges because, paradoxically enough, freedom is not without price.

To return to the recital of services which are tendered you with your membership card, may I refer to the Council on Medical Service through whose studies, meetings, and liaison activities great progress has been made in making better medical service available to more people at prices which they can afford through hospital, surgical and medical insurance, the establishment of grievance committees and emergency call services, community health councils, and in many other ways.

Gain Public Good Will

The medical profession can have no better advantage than the public good will accruing from its services to patients, not only in individual practice but through organized medicine.

In a similar way, the Council on Industrial Health has not only helped to promote health and safety in industry but has improved relationships among employers, physicians and workers to the mutual benefit of all.

So has the Committee on Rural Health, the Committee on Emergency Medical Service in the event of war or disaster, and the Commission on Chronic Illness in which the Association is one of four major participants. Each of these in its own field renders a service to every individual doctor when it serves the people and enhances the value and the prestige of the medical profession as a whole.

Investigate Quacks

The Bureau of Investigation, one of the oldest A.M.A. departments, beginning before the turn of the century as a column in the JOURNAL entitled "Propaganda for Reform," continues its unceasing war on quackery and frauds, though its task has been lessened by the heightened activities of the Post Office Department, the Food and Drug Administration and the Federal Trade Commission in these areas. No small measure of this government activity is attributable to the influence of the medical profession.

(To be continued in the April Medical Forum)

LIBRARY OF THE COLLEGE OF PHYSICIANS

MORE HELP NEEDED FOR HANDICAPPED CHILDREN

Committee Reviews 1951 Report; Suggests Areas for Improvement

Madison, Feb. 15.—How do handicapped children fare in Wisconsin?

What is being done to help the polio cases, the cerebral palsied, the speech defectives, the deaf or hard-of-hearing, the visually handicapped, the rheumatic fever victims and the orthopedically handicapped?

All the answers can't be found in one place, but the State Medical Society's Advisory Committee on the Care of Crippled Children recently got a report on what the Bureau for Handicapped Children of the Department of Public Instruction is doing for these children in Wisconsin.

The committee, under the chairmanship of Dr. Henry Sincock, Superior, met on January 27 to review a report of the bureau which it serves to advise on medical matters affecting the care of the handicapped child.

Summarize Activities

The statistics covering 1951 may be mere columns of figures, but the committee viewed them as a dramatic story of the relief and prevention of human suffering. Here is a brief summary of the report:

Thirty-eight orthopedic clinics were held in 1951. Eighteen orthopedic surgeons examined 2,159 children. Most of the children were polios, spastics or victims of conditions of the feet and legs.

Twelve orthopedic schools were operated in 1951 with 777 children enrolled and 498 handled as outpatients. The average cost for 5 days' care in boarding homes was $13.05.

Nearly 8,000 children received services in the defective speech program. Sixty-nine speech correctionists work the state.

A special school for deaf children and their parents was held at Wisconsin State College in Milwaukee. In addition, 200 children were enrolled in the school for the deaf at Delavan; 80 at St. John's in Milwaukee; and 420 children were enrolled in 14 day schools for the hard-of-hearing.

DR. H. A. SINCOCK

Members of the Committee on Care of Crippled Children

Dr. Sincock, Superior, Chairman
Dr. A. B. Schwartz, Milwaukee
Dr. C. M. Kurtz, Madison
Dr. W. P. Blount, Milwaukee
Dr. C. M. Ihle, Eau Claire
Dr. R. E. Housner, Richland Center

Over 45,000 school children were given audiometric screening tests. This produced evidences of hearing impairment in 1,011 children who were subsequently examined in clinics with the help of 16 participating otogolists.

About 145 children are enrolled in the residential school at Janesville for the visually handicapped. In addition, 135 are enrolled in 9 special "sight-saving" classes at day schools.

Five Urgent Problems

Individual psychometric studies are available for any child upon request at the orthopedic field clinics. About 500 evaluations of this type were made in 1951.

Over 3,500 children were enrolled in 178 special classes for the mentally handicapped.

Nearly 85 clinics were held for rheumatic fever victims.

Significant as these activities are, the Medical Society Advisory Committee on the Care of Crippled Children pointed to several problems still in need of solution:

1. **lack of personnel has hampered development of an effective statewide program for those suffering defective speech.**
2. **a great need for parent education in problems of the visually handicapped. There is also need for a visual screening program like that used in hearing.**
3. **a noticeable increase in preschool blindness directly associated with the great increase in premature births.**
4. **a "disturbing tendency" to provide hospitalization for polio "far beyond the period of benefit to the patient." In some cases there is excessive use of physical therapy without proper medical supervision.**
5. **community projects of home care for rheumatic fever victims are needed throughout the state. They are less expensive than convalescent home care and easier on the family members concerned.**

The committee also approved the program of the Wisconsin Association for the Disabled which will operate through the Cerebral Palsied Center at the University of Wisconsin.

13 Hill–Burton Hospitals Now Operating in State

Madison, February 1.—Thirteen hospitals built under the Hill–Burton Construction Act are now admitting patients in Wisconsin, according to Vincent F. Otis, director of the hospital services division of the state board of health.

A total of 34 projects have been approved since the program began in 1947. Seventeen projects are over 90 per cent completed.

The 13 projects already completed and in operation were built at a cost of nearly $12 000,000 including federal contribution of $3,-125,000. They supply the state with 642 additional hospital beds.

Dr. Alfred L. Castleman, Agitator and Critic

By DONALD R. McNEIL
Madison

THE young doctor, his tall slight form braced against the buffeting autumn winds, strode the rutted streets of Milwaukee, the lakeside village. His dark eyes thoughtfully measured the offerings of this new land. It was 1835 . . . a new territory was in the making . . . Alfred Lewis Castleman, M.D. had arrived to contribute his particular talents.

Castleman, like many pioneer Wisconsin doctors, made little contribution to the scientific development of medicine; yet his vigorous efforts to strengthen the State Medical Society and to secure an insane asylum and a medical school for the growing state of Wisconsin placed him in the front ranks of those doctors who sought medical reform.

Politics, too, came in for his consideration. Doctors in pioneer communities, often venerated for their healing of the sick, found themselves placed before constituents as candidates for public office. Castleman was no exception and his devotion to political matters culminated in his election to Wisconsin's second constitutional convention in 1847.

DR. ALFRED L. CASTLEMAN*

Outspokenly critical, yet at times keenly incisive, Castleman's high-strung temperament brought him a lifetime of conflict as he assumed the role of agitator and promoter in the fields of medicine and politics.

The Civil War offered him the climactic opportunity of exercising his critical bent, and he used this talent to fight for better health conditions for soldiers serving under him. Like the troops in grey, Castleman, after Appomatox, vainly tried to return to the influential position he enjoyed in ante-bellum days. Instead, coolness, neglect and indifference greeted his every move. Never again did Castleman hold counsel with the political and medical powers of the state.

But the young doctor walking the streets of Milwaukee village had no inkling of the future in store for him. Born and raised in Kentucky, Castleman had come to the frontier to practice medicine. Ambitiously aware of the possibilities awaiting a young doctor in this new land, he bought a farm in Delafield and practiced there and in Milwaukee until after the Civil War. His training at the Louisville Medical School stimulated his hopes for advancing the standards of his profession, but his contributions to medical progress lay more in the organizational than in the scientific sphere.

Though later recognized as a local surgeon of note, Castleman accepted the prevailing theories of disease causation and approved the standard treatments of bleeding, purging and vomiting patients for a variety of ailments.

During the cholera epidemic of 1849 he publicly denounced the idea that the dreaded malady was infectious. "Be assured that the disease *is not* contagious," confidently stated the doctor; it is an epidemic "propagated by atmospheric causes." In 1851 one of Castleman's fellow Milwaukee doctors appeared in circuit court to answer charges of malpractice rising out of the death of a four-year-old girl due to "large doses of calomel." When the jury freed his colleague, Castleman joined a "mass medical meeting" and helped write resolutions tendering congratulations to the accused physician. His participation in such mass meetings and his leadership in local and state medical societies demonstrated his particular interest in organized medical action.

Ante-bellum medical societies were ephemeral organizations, characterized by small and often indifferent memberships. Only a few doctors like Castleman steadfastly campaigned to solidify the ranks of the profession. In the 1840's Castleman helped found the Milwaukee County Medical Society and the Milwaukee City Medical Association, but meetings of both groups were spasmodic and the

* All illustrations were supplied through the courtesy of the State Historical Society.

lethargy displayed by doctors toward medical organizations resulted in dwindling memberships.

The same apathy among doctors prevailed in the State Medical Society as in the local organizations, and Castleman, as President in 1849 and 1850, vigorously led the small group of physicians in their efforts to enlarge their membership.

Prior to 1854, in order to prevent "clogging the Society with too large a number," the charter of the State Medical Society limited membership to two new members annually. The legislative restriction operated as a hindrance to expansion, for with only a few allowed to join each year, doctors were reluctant to participate in Society proceedings.

Castleman's two year tenure as president saw the Society make a determined bid to secure repeal of the membership provision from the legislature, but not until 1854 did the lawmakers act. With the restriction repealed and Society membership unlimited, delegates to the annual meeting elected Castleman president of the reorganized State Medical Society of Wisconsin. Castleman's expectations of growth proved illusory; membership continued to dwindle until the Civil War when Society activities ceased.

Besides his strenuous efforts to remove the irritating membership proviso, Castleman assumed an outstanding role in three other projects of the Society—the fight against quackery, the attempt to organize a medical school, and the effort to establish a State Lunatic Asylum.

Quackery was always a prime concern of the State Medical Society. In an era when no laws, nor codes of ethics bound the healers in their medical practice, homeopaths, eclectics, hydropaths, clairvoyants, Thomsonians and patent medicine men flourished in the wake of public dissatisfaction with the allopathic or regular doctor and his standard treatment of bloodletting and administering emetics and physics.

To combat their medical opponents, Castleman and members of the State Medical Society hoped to use their organization as a vehicle for condemnation of their medical opponents. Their efforts to eradicate the influence of irregular physicians ended in conspicuous failure.

In January 1850 Castleman, as president, appointed a committee of one physician from each county to report the names of all Wisconsin practitioners and instructed the committee members to distinguish between physicians with M.D. degrees or diplomas from "some incorporated medical college or society," and those who practiced "without any authority." In the June meeting the secretary complained that he had received only a few reports —and many of those were "imperfect and incorrect." As non-society members and "irregulars" had served on the committee, they had reported "quacks as doctors."

The next year Castleman again appointed a committee to study means for the "protection of the public from quacks, quackery, patent medicines and nostrums," but no action resulted.

In 1855 in his valedictory address as president of the State Medical Society, Castleman, in a speech commended by newspapers as "able and instructive," "eloquent," and a clear exposition of the "*true* policy to meet and overcome quackery," emphasized the importance of organized efforts to raise medical standards.

The outgoing president outlined the menacing rise of quackery. Living by allopathic opposition, "fattening on . . . abuse," and "revelling in ridicule," the "great evil of empiricism" had gained the sympathy of the public and the sanction of the laws. As quackery often existed "under cover of a diploma" as much as under the "dogmas of Thomson or the feeble vagaries of Hahnemann," said Castleman, medical societies had to be "kept up."

A two-pronged offensive comprised his effectual campaign against quackery. Let every legislator "be approached" on the subject of medical regulation, Castleman frankly advised. Show them a few of the "inconsistencies" on the statute books. Point out the "liberal provisions" which protected people from the purchase of bad whiskey, while the lives and health of people were entrusted to the "mercy of the ignorant and mercenary venders of drugs and medicines." Show the lawmakers how they punished "counterfeiting the penny or dime," and yet complacently looked on and provided no punishment for

Milwaukee in 1836 the year after Castleman arrived in the pioneer community.

those who "counterfeit the physician and cheat us of our health and our lives."

"It is *our* duty," claimed Castleman, "to relieve the community from the curse of quackery." Besides seeking legislation, he bluntly warned the Society members, they must "leave off . . . abuse" of the irregulars and by their "*high example* excite the empiric to become a man of science." The Society, in order to make the reform permanent, must "demand of the community" the means for providing facilities for proper scientific education.

Newspapers picked up Castleman's plea for a medical school and supported it. The *Waukesha Plain Dealer* said the idea was a "good one" and could see no reason why the medical profession should not "receive some little support from the State." The *Milwaukee Sentinel* agreed that a medical school would effectively combat quackery. The influence of a school and the "effect of such counsels as Dr. Castleman's," said the editor, would "contribute most effectually to arrest the growth of medical imposture, and save the people from being victimized by quacks." It was time, urged the editor, that Wisconsin had its own medical school instead of having to send its young men out of the state to prepare for a medical career.

In endorsing the idea of a Wisconsin medical school, the *Sentinel* editor hit upon one of Castleman's favorite projects—his attempt to work through the State Medical Society to establish a medical department in the University of Wisconsin.

In 1848 when the state legislature established a state university, the lawmakers had arranged for a separate department of medicine, but without appropriations the regents were unable to implement the plan. Castleman's appointment in 1850 by the State Medical Society to confer on the subject with the University Chancellor, J. H. Lathrop, marked the first attempt of the Society to make the authorized medical department a reality. After discussions with Chancellor Lathrop, Castleman reported back to the Society that because of lack of funds such a move would at that time be "inexpedient."

Five years elapsed before the University regents revived the idea of a medical department with appointment of a complete faculty to the University of Wisconsin Medical Department. Castleman received the professorship of Theory and Practice of Medicine. But the new department was a medical school in name only, and the professorial positions were strictly honorary. Lack of appropriations again delayed the opening of a medical school for Wisconsin.

The 1855 legislature acknowledged Castleman's role as a leader in the drive to establish a medical department by electing him a regent of the University. The following year when the University gave him an honorary M.D. degree, the editor of the *Milwaukee Sentinel* commended the regents for honoring the man who had "contributed more than any other one to the establishment of the Medical Department of the University," and who had "always shown himself ready, by pen and purse alike, to aid the advancement of science."

But Dr. Castleman's pen and purse were beginning to feel the strain. He had spent "over $1,000" on the venture and shortly after he received his honorary degree he wrote Chancellor Lathrop that though the department had to be "put into operation at any cost," he was "not willing to risk any more" without some financial help.

Convinced that the doctors had done more than their share toward instituting the new department, Castleman felt sure they could no longer be prevailed upon to undertake the project until more "liberality" was shown on the part of "their rulers." Why should the doctors expend time, money and reputation, angrily asked the doctor, when they were under the direction of another body with power to control all their actions, and impose upon them their partners "without giving anything in return either by way of appropriation or annuity!"

A month later, when he resigned his position as professor, he again protested against control of the medical department by any other group than the doctors. Because he felt doctors should designate the professors of medicine and because he had been appointed by a non-medical board, the regents of the University, he decided to "labor in the ranks" until promoted by his own profession. Not for many years was a medical school to become a reality.

Castleman's third large-scale objective was the establishment of a State Lunatic Asylum. Upon the recommendation of Democratic Governor William A. Barstow, the state legislature in 1854 had enacted a law creating a State Lunatic Asylum. Administration opponents hurled charges of fraud and foul play in awarding the contract and in the next legislative session managed to repeal the measure.

Into these scenes of partisan conflict stepped Castleman with his hopes for greater control of such institutions by the medical profession. At the annual meeting of the State Medical Society in 1856, Castleman, as chairman of a committee to investigate the possibilities of an Asylum, reported there were 240 insane cases in the state. He and his committee objected to the name "Lunatic Asylum;" they wanted a "Hospital for the Insane," where patients could be "medicated," and where "medical appliances" could be used to restore the mentally ill to sanity. The Medical Society delegated the committee members to memorialize the legislature accordingly, but the bill to create an Asylum failed to pass.

Castleman had personal reasons for manifesting concern over the plight of insane people in the state and for guiding the Society into the position of endorsing the establishment of a Hospital for the Insane. He stood to gain financially from it and at one time hoped to make it his private Asylum where, for a fee, he would care for the insane wards of the state.

He proposed that the state loan him $10,000, and together with $25,000 of his own he would purchase a site and erect the necessary buildings. The Asylum, on terms to be arranged by himself and the state, would "take care of all the State Lunatics," and give preference to state over private applications.

If the state would accept his proposal, stated Castleman, it would save at least $20,000 and yet "be a profitable investment for me." Any "rational man," declared Castleman with customary vigor, would acknowledge that an individual "working for his own interest" would accomplish more with $35,000 than the State would with $70,000, and that, after the buildings were erected, patients could be cared for at "half the cost" by an individual than they could be by the State. The legislature passed a lunatic asylum act that session but not according to Castleman's desires. The lawmakers invested control of the institution in a board of three commissioners, and three years later the Hospital for the Insane began operations near Madison.

A Civil War surgical kit similar to one carried by Doctor Castleman during his service with the Army of the Potomac.

While busy campaigning strenuously against "irregular" doctors and for a medical school and State Lunatic Asylum, Castleman, in parallel efforts, based his bid for political power on his reputation as a doctor and as one of the chief medical organizers in the state. Prior to the Civil War recognition as a leader of Wisconsin medicine carried with it little in the way of influence. One of the few paths to power and prestige led through the ranks of party politics.

Believing in the "correctness and policy of Whig principles" in the early years, Castleman held minor local offices and was an unsuccessful candidate at one time for the territorial assembly. In 1846 he fought the forces headed by two future governors of Wisconsin, Alexander Randall and William A. Barstow, who were agitating to create a new county out of Milwaukee. Castleman and the "Unionists" lost their battle, but his neighbors in the newly-formed Waukesha county immediately elected him county supervisor.

The following year Castleman reached the zenith of his political career when his district sent him to the second Constitutional Convention. Serving on the important committee on banking and corporations, the doctor participated extensively in convention proceedings and was instrumental in solving the highly controversial banking problem.

When the slavery issue burst again upon the nation in 1854, Castleman organized mass meetings, helped write resolutions against slavery, and aided in the formation of the Republican party on the local level. In 1855, though spoken of as the "man for the times" for the office of secretary of state on the Republican ticket, Dr. Castleman lacked the necessary votes at the state nominating convention and lost his one chance for high state office.

Castleman spent the remaining years before the Civil War lecturing before lodge groups and civic organizations and again concentrating on his medical practice. In 1857 he purchased a water cure establishment in Madison but retained the supervisor to run the "Lake Side Water Cure" as a resort.

When war came in 1861, Dr. Castleman eagerly supported the Union cause and in June 1861 joined the Fifth Wisconsin Volunteers as Regimental Surgeon. No sooner had the Regiment assembled at Camp Randall in Madison than Castleman began advertising for donations of bedding and fresh food for his sick soldiers and publicly rebuked the women of the state for losing enthusiasm displayed in the first days of the war.

Castleman kept a journal during his war service and after his resignation in 1863, had portions of it published under the title, *The Army of the Potomac, Behind the Scenes*. The printed version traced his service with the Fifth Wisconsin from June 1861 through the battles with General George McClellan's Army of the Potomac.

Castleman studded his account with frequent and bitter denunciations of his fellow surgeons, his military commanders, and the management of the war. Devoting long hours to the maintenance of health among troops, Castleman vigorously condemned medical practices which did not square with his own theories of treatment. When he heard "scientific men, in scientific discussions," attributing "hospital gangrene" and "low typhoid fevers" to foul air, he considered such statements absurd. Scoffed Castleman, " 'Twas a gangrene of the mind, for want of ventilation of the brain." Complaining about the "very bad surgery" he had seen, he cited one experience when two out of four amputations "*had to be amputated* a second time."

Carrying his remonstrance to the root of the trouble, the doctor condemned the governors of the states for succumbing to the pressure of party politicians and appointing surgeons whose only "notoriety" consisted of their ability to "stand up under the greatest amount of whiskey."

The surgeon had his own ideas on treatment of the sick and preservation of health. A good "mental atmosphere" in hospitals was conducive to recovery,

and he believed that nostalgia often lapsed rapidly into typhoid fever and brought death. A stickler for ventilation and cleanliness, Castleman felt that any surgeon who was unwilling to visit every tent in his encampment at least once a day did not deserve to be an army surgeon.

The indifference of his superior officers to the health and welfare of the men galled the outspoken doctor and petty quarrels with colonels and generals punctuated his eighteen-month army career. He decried the jealousy existing between military officers and surgeons; he attacked his superiors for failing to insure sanitary camp conditions; he condemned the inequalities between officers and enlisted men; and, despite threats of court martial, persistently demanded an adequate staff of trained nurses, cooks and hospital stewards.

Castleman's chief grievance, however, was military interference with his duties as a surgeon. One day in October 1861, Dr. Castleman, with a growing sick list confronting him, became "excited," and told Colonel Amasa Cobb that interference must stop and that as surgeon he would "submit to it no longer." Angered at the outburst, Colonel Cobb hinted darkly at a court martial for insubordination and the regimental surgeon became worried. The quarrel reached its climax a few days later. Castleman was touring the camp, giving explicit instructions about cleaning tents. Colonel Cobb strode up, watched the doctor issuing his orders, and abruptly commanded his men to disregard any orders of Surgeon Castleman until the Colonel personally sanctioned them. When Wisconsin's Governor Alexander Randall, whom the doughty surgeon had battled years earlier in the fight over the division of Milwaukee county, visited the regiment a few days later, Castleman laid his grievance before the chief executive. Next day the colonel returned the sanitary care of the camp to Surgeon Castleman.

The doctor's criticisms of his immediate superiors often branched off into wholesale condemnation of the war. He hated the red tape and the military restrictions. When he saw affairs conducted for "political effect at home," he considered the war a "humbug, and our Government a failure." He believed General McClellan was "nothing short of an imbecile, a coward, or a traitor," and he condemned war profiteers as "*loud mouthed* patriotic capitalists," who cheated the soldiers in the "very clothes they wore to battle" to protect the wealth of the money makers.

Camps such as this one in Chattanooga, Tennessee, were visited by Doctor Castleman on his trips for the U. S. Sanitary Commission.

Disgust with military life, coupled with failing health, caused the outspoken surgeon to resign in December 1862. He had seen a good deal of combat during his year and a half in the Union Army. Soldiers wrote home several times commending the doctor for gallantry in action and for the fine care he gave his regiment.

In 1863 Castleman joined the U.S. Sanitary Commission as commissioner for the Army of the Cumberland and distributed supplies of the civilian agency to the battlefields. His capture by Confederate forces highlighted his service with the Commission. Returned to Union lines when his Confederate captors discovered he was acting in a civilian capacity, Castleman added another exploit to a vigorous life.

After the war, sickness continued to plague Castleman and he failed to renew his pre-war medical and political activities. His absence from the group that reorganized the State Medical Society in 1867 showed his lack of interest in collective action—once manifested by his intense organizational activities.

Though he confined his efforts almost entirely to rebuilding his practice, business came slowly. Younger doctors competed successfully for his former patients, and he never developed his practice to the pre-war level.

Now and then the voice of the pioneer doctor was heard—but never in the strident tones sounded during the pre-Civil War period. In 1866 he carried on a running newspaper fight with another doctor over the question of whether or not cholera was contagious. Completely reversing his opinion voiced years earlier, he took the stand that Wisconsin's Surgeon-General Erastus B. Wolcott was wrong when he reported that cholera was not contagious. Castleman cited many cases where he could prove that cholera was contagious.

From time to time newspapers reported the old pioneer's activities. They commended his appointment as marine surgeon for Milwaukee, noted operations he had performed, and told of his sicknesses and accidents. In 1872 his call for a reunion of the living members of the Constitutional Convention of 1847 signified his total eclipse as an important force in Wisconsin medicine.

Though he tried to relive the past, Castleman realized the times had passed him by and became resigned to the new forces abroad in the land. In the twilight of his career he summarized his feel-

ings in a letter to a local newspaper: The "fogies of the older times are being elbowed out and aside by Young America."

During the Civil War, winter quarters like these in Virginia were hard to keep clean and Surgeon Castleman spent most of his energies trying to secure a satisfactory sanitation policy.

His realization that America was in a process of transformation brought him some peace of mind, but his body suffered from the frequent attacks of disease. In 1875 he moved to California, hoping to regain his health, and on August 22, 1877, he died in Oakland.

Throughout his many years of agitation, Castleman had often reduced his own effectiveness by his extremist views and outspoken agitation; he dissipated much of his energy in local, political agitation. Yet his fights for more influential medical organizations, an insane asylum and a Wisconsin medical school were pioneer efforts and later generations reaped the harvest of his efforts. His condemnation of medical and sanitary conditions during the Civil War was an honest and vivid portrayal of army life in which he reached the height of his influence.

Though partially the product of his time and environment on the frontier, Castleman impressed the stamp of his particular influence indelibly upon the development of medicine in Wisconsin.

ANNUAL MEETING OF WISCONSIN TRUDEAU SOCIETY ANNOUNCED

Dr. Einar Daniels, secretary of the Wisconsin Trudeau Society, has announced the program for the annual meeting of the Wisconsin Trudeau Society. The meeting will be held April 5 in the East Room of the Schroeder Hotel.

The program is as follows:

9:00– 9:30—Registration.

9:30–10:00—Lung Immobilization (Barach) Therapy—A Clinical Study: Roger A. Hemphill, M. D., Wood.

10:00–10:30—Unusual Clinical Pictures in Bronchogenic Carcinoma: Hiram T. Langston, M. D., Chicago, Ill.

10:30–11:15—Small Resections in the Treatment of Pulmonary Tuberculosis Following Maximum Improvement on Long Term Chemotherapy: John D. Steele, M. D., and Robert K. Salter, M. D., both of Milwaukee.
Discussants: George Owen, M. D., and Anthony V. Cadden, M. D., both of Milwaukee.

11:15–11:45—Lobectomy for Tularemic Abscess (Case Report): Earl Sanborn, M. D., Chicago, Ill.

12:00– 1:30—Luncheon.

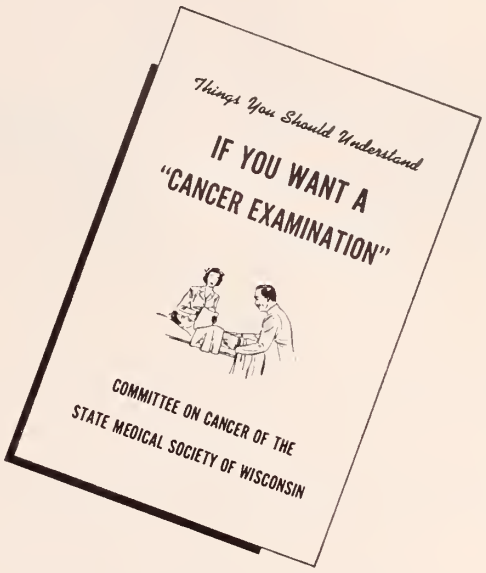
1:30– 1:45—Business meeting, election of officers.

1:45– 2:30—Studies on Pulmonary Function: Richard V. Ebert, M. D., Minneapolis, Minn.
Discussant: Paul Jahn, M. D., Milwaukee.

2:30– 3:00—Cortisone in the Treatment of Sarcoidosis (Case Report): William J. Little, M. D., Wisconsin State Sanatorium, Wales, Wisconsin.

3:00– 3:45—Tuberculosis in Children: James M. Wilkie, M. D., Madison.
Discussant: Helen A. Dickie, M. D., Madison.

607 MD's Responded!



THE illustration on this page is a reproduction of the cover of a recent publication of the Committee on Cancer. It is not new to many of you. At the time of this writing, 607 Wisconsin physicians have requested and received 111,000 copies for distribution to their patients in waiting rooms and as enclosures with their statements. A response of such magnitude indicates a wide approval and a belief that the pamphlet's message might go far toward improving the physician-patient relationship in this problem of cancer detection.

It is of interest that the Committee on Cancer in Ohio has reviewed this publication with enthusiastic interest and is planning a similar distribution through Ohio doctors in the near future. An inquiry has also been received from Connecticut. The public relations department of the American Medical Association has expressed a keen interest.

A careful analysis of requests for the pamphlet reveals that many physicians have too small a supply and have possibly already exhausted the number on hand. Additional copies may be had at any time by sending a request in the form of a letter or post card to The Wisconsin Division, American Cancer Society, 652 East Gorham Street, Madison 3, Wisconsin.

April is cancer control month in Wisconsin and throughout the nation. This is the time of year when the American Cancer Society is bringing to a climax its year-around public education efforts and conducting its appeal for financial support of the program of research, education, and service. You can play a vital part in this activity by ordering and distributing to your patients this pamphlet, "Things You Should Understand If You Want A Cancer Examination."

A. R. Curreri, M. D.

Chairman, Committee on Cancer

. . . . THE PRESIDENT'S PAGE . . . .

Now Let's Turn the Page

I HAVE been writing about patients' complaints for several months. Now it is time for a short discussion of the doctors' problems and what can be done about it.

The average doctor works 70 or 80 hours a week—more during epidemics—which is far more than most persons do. He needs rest and recreation as well as other human beings. Yet there is never any time, day or night, when he can fully relax and know that he will not be called to duty at a moment's notice. All of us recognize this fact when we enter the profession. No doctor resents the interruptions at odd hours if they are justified by emergencies or a real need for his services.

The things that present the most problems, because they interfere with our necessary rest and recreation and completely disrupt our family and social life, are the following:

1. Unnecessary calls at night and on Sundays and holidays. Careful checking has shown that, with the exception of accidents and obstetric cases, nine out of ten night calls are not emergencies. Many of these calls are made only for the convenience of the patient or his family.
2. "Hurry up" calls with an unreasonable demand for immediate service when no emergency exists, especially during office hours, at meal time, and during the rare recreational and rest periods of the doctor.
3. Other sources of aggravation, which also interfere with giving prompt and efficient service are the following: inadequate or wrong information concerning the condition and location of the patient, calling more than one doctor at the same time on emergency calls, and failing to give the correct name of the patient.

Most of this trouble is due to thoughtlessness and lack of proper information as to how to secure good and prompt medical attention. This is especially true because many people "lose their heads" when things go wrong and they are anxious and excited. What they do not know is that much of this annoyance is unnecessary and in many instances borders closely on the ridiculous.

I believe that if we undertake the task of giving dignified, systematic information to the people on "how to help your doctor give you better medical service" that it will do a tremendous amount of good.

This should include such subjects as when to call a doctor, what an emergency is and when it is safe to wait, and what information should be given when making a call so that the doctor can be prepared to administer the necessary treatment.

An outline of such articles will be prepared by the State Society but to be effective they must be modified to meet local conditions. They should be distributed and published as advertisements and news stories on a local level under the name of the county medical society or the names of all the physicians in a city or town. I am sure that the local press and radio will publicize this information because it will be of service to their readers and listeners.

I urge you to cooperate in this further step toward making medical service better and more efficient and improving our public relations.

Albin T. Heichmann M.D.

COMMITTEE *Concentrates*

COMMITTEE ON GRIEVANCES

FEBRUARY 3

MDs Present: R. E. Fitzgerald, F. A. Nause, C. E. Zellmer, E. W. Mason, E. D. Sorenson, and H. W. Wirka.

Because of the confidential nature of the work of this committee, details will not be reported, but meeting dates and attendance will be recorded, so the membership will be apprised of the continuing activity.

COMMITTEE ON INDUSTRIAL HEALTH

FEBRUARY 3

Conference on Medical Problems Relating to Migrant Workers: MDs Present: A. H. Heidner, D. E. Dorchester, J. C. Pinney, E. G. Nafziger, H. J. Kief, C. N. Neupert, and H. M. Coon.

Meeting with representatives of State Industrial Commission, State Board of Health, Public Welfare, and Governor's Commission on Human Rights, to air views on problems of summer workers from Texas, Mexico, and West Indies. . . . Problem of determining local relief agency responsible for care of workers brought out. . . . All county societies will be supplied with summary of local agencies to contact, before need for authorization of care arises. . . . Hospitals in areas where high concentration of workers will be encouraged to set up routine exams for VD and TB on all migrant workers admitted. . . . Need for educational program for children of workers stressed . . . major problem that of Texan Mexicans, not those admitted under contracts from Mexico proper or West Indies.

ADVISORY COMMITTEE TO W.I.A.A.

FEBRUARY 6

MDs Present: J. S. Supernaw, W. R. Manz, C. M. Carney, and H. F. Schroeder.

Major purpose to clarify and simplify pamphlet sent to students, parents, and schools on details of the program, including clear statement on payment, to avoid common idea that the program is "full payment." . . . Forms prepared to simplify payment procedures and to make crystal clear what situations are NOT covered. . . . Fee schedule being related to insurance programs under WPS and WP. . . . Problem of denying payment to MD when boy returns to competition in violation of rules discussed, but no "meeting of minds" achieved. In such cases W.I.A.A. denies benefits, and MD has to collect from parent.

MILITARY MEDICAL SERVICE

FEBRUARY 8

MDs Present: F. L. Weston, O. G. Moland, M. J. Musser, and C. N. Neupert.

Doctor Weston made a detailed report on present status of Priority I and II registrants: 39 out of 230 Priority I registrants have been placed in 4-F classification; 18 have been considered available but have not accepted commissions offered them. . . . Wisconsin and many other states have protested Defense rules which have worked to disadvantage of MDs who volunteered for commissions in belief that those in same priority who declined commissions would be drafted. Present rules contradict initial announcements, so the "eager beavers" are left holding the bag . . . individual situations carefully reviewed, and recommendations made on several cases which indicated need for relief from regulations being applied . . . this committee has met a number of times, and has devoted many hours to consideration of cases where the MD or the community have felt that he should be declared essential.

JOINT MEETING WITH WISCONSIN BAR ASSOCIATION

FEBRUARY 14

MDs Present: A. H. Heidner, J. C. Griffith, and Members of Grievance Committee: R. E. Fitzgerald, E. W. Mason, F. A. Nause, E. D. Sorenson, H. W. Wirka, and C. E. Zellmer.

Major emphasis of meeting on Problems of Attorneys in Their Relationships with MDs, and Problems of MDs in Their Relationship with Attorneys . . .the variety of questions raised suggested the need for a continuing joint committee to develop and report back on an interprofessional code, as well as making recommendations looking toward the planning of articles in publications of both groups, medical-legal institutes, and possible courses in professional schools on subjects of joint interest and concern to the two professions.

COMMITTEE ON BLOOD BANKS

FEBRUARY 15

MDs Present: W. D. Stovall, C. N. Neupert, T. J. Greenwalt, Ethelred L. Schafer, and Merle Owen Hamel.

Primary purpose to review status of blood procurement program and to make recommendations to Council. . . . Set up procedures to encourage local MDs to provide supervisory assistance when bloodmobile from Madison visits area, either as part of regional blood program or procurement of blood for military needs. . . . Recommended to Council continuation of committee for at least another year and recommended to Civilian Defense authorities that fluid blood be stored in Milwaukee Blood Center and used on rotation, to avoid spoilage. . . . Directed Doctor Greenwalt to prepare material for *Journal* emphasizing need for conservation of blood by MDs.

SCHOOL HEALTH PLANNING COMMITTEE

FEBRUARY 17

MDs Present: Amy Louise Hunter, Maxine Bennett, John Brown, and E. H. Pawsat.

Reviewed possibilities of holding state conference on school health some time next fall. . . . Appointed Mr. Fred Holt, superintendent of schools at West Bend, as chairman of special steering committee to work out details . . . agreed to have primary sponsor that of the Wisconsin School Health Council, which has representation from 33 agencies interested in school health . . . School Health Committee of SMS will be called into session this spring to go over whole proposal. . . . Council has approved participation of SMS in such a state program, in keeping with recommendations of A.M.A.

INTERIM COMMITTEE OF COUNCIL

FEBRUARY 23

MDs Present: A. H. Heidner, S. E. Gavin, J. M. Bell, J. C. Griffith, R. G. Arveson, and Roman Galasinski.

Reviewed film from Metropolitan Life entitled "Cheers For Chubby" which will be offered movie outlets for free educational showing. Approved of cooperation on showing of film. . . .Problem of hospital practices in making charges for such items as routine blood pressures referred to Council on Medical Service by approval of Council. . . . Recommended that Council meet at time of Rural Health Conference next fall, to provide better MD representation. . . . Did not approve of suggestion offered that extra session of the House of Delegates be held yearly to devote entire time to medical economics. . . . Suggested that Council extend invitation to A.M.A. Council on Rural Health to bring the National Conference on Rural Health to Milwaukee in 1954. . . . Problem of impending litigation on pharmacy matter discussed.

ANNUAL MEETING OF THE COUNCIL

FEBRUARY 23–24

MDs Present: H. Kent Tenney, H. E. Kasten, E. M. Dessloch, A. H. Heidner, A. J. McCarey, J. C. Fox, J. M. Bell, E. E. Kidder, R. G. Arveson, R. E. Galasinski, E. L. Bernhart, J. S. Supernaw, R. E. Fitzgerald, C. N. Neupert, S. E. Gavin, J. C. Griffith, and W. D. Stovall.

Primarily a business meeting and action taken on the budget. Officers elected: R. G. Arveson, chairman of the Council; F. L. Weston, treasurer; C. H. Crownhart, secretary; R. S. Baldwin, Marshfield, re-elected medical editor of *Journal;* J. M. Sullivan, Milwaukee, re-elected editorial director of *Journal* . . . H. Kent Tenney succeeded late Dr. Byron Hughes as Speaker of the House, and W. D. Stovall, Madison, named vice speaker. . . . Staff re-assignments made: Thomas Doran becomes general claims director for all SMS programs; Ralph Weber named business administrator for WPS . . . Byron Ostby named field secretary as of April 1 . . . Earl Thayer's duties expanded to handle all publicity for WPS in addition to public information work with SMS proper. . . . Dr. J. C. Fox, La Crosse, re-elected to Interim Committee for three year term.

COMMISSION ON PREPAID PLANS

MARCH 1–2

(The preceding afternoon and evening were devoted to meetings of the Commission's committees: Executive; Claims; Enrollment and Underwriting; and Physicians and Public Relations.) MDs Present: E. M. Dessloch, J. C. Griffith, Richard Foregger, T. D. Elbe, Robert Krohn, W. C. Stewart, G. W. Carlson, J. W. Truitt, J. T. Sprague, N. A. Hill, C. G. Reznichek, K. H. Doege, R. E. Garrison, R. M. Moore, Charles Fidler, and J. S. Supernaw.

Highlights:

Reviewed line by line the new Blue Shield contract designed to effect the new schedule of benefits and the two-income full payment plan.

A knotty problem: medical care benefits are based on a "day" basis. How should "day" be defined? Action: each 24-hour period following the patient's admission to the hospital.

The new contract will show which coverages apply to the holder.

Infants will be covered beginning with the fourteenth day of age.

Full payment benefit includes the services of the assistant, as well as the operating surgeon; the maximum benefit is that in the schedule of benefits; the surgeon and the assistant may bill separately but within the maximum.

The old provision that anesthesia benefits are provided when the service is performed by a physician other than the surgeon or his assistant is abolished. The only condition, other than contract conditions, is that this service be performed and billed by a physician.

The contract is in its eighth draft and is more than 10 typewritten pages in length. The many important provisions can't be summarized here, and so you may expect a general membership mailing in the near future relative to the whole program.

Other Important Commission Action:

Approved an administrative budget of approximately $138,000 for 1952, exclusive of Blue Cross sales expense.

Identity of physician payees, and extent of participation by physicians, held to be a confidential matter.

Approved a procedure for securing reimbursement to the Society of its expense in its administration of Wisconsin Plan, such as handling disputed claim matters for physicians, legal expense in analyzing contracts, stenographic and secretarial expense.

Authorized Blue Shield administration to assume direction and final determination of the publicity program developed to inaugurate the new plans.

Received and referred for further study a recommendation of the Committee on Enrollment and Underwriting that Blue Shield be made available to groups numbering from five upwards—present rule: 10 or more.

Took the same action upon the recommendation of same committee that community enrollment be undertaken, with the Commission specifically to approve area, advertising media, cost, and underwriting factors involved.

Approved recommendation of Claims Committee that electrostimulus therapy be regarded as medical and not surgical treatment; also, approved an abbreviated schedule of benefits recommended by the committee for publicity and informational purposes.

Approved recommendation of the same committee that a fee of $25 be established for electro-dessication of tonsils.

Received for future study a number of recommendations of Committee on Physicians and Public Relations, and particularly that:

County medical societies invite members of the Commission and of the staff to explain the new program.

Area conferences for employees of physicians (secretaries, office employees, business managers) be scheduled at an early date.

Notification be sent county medical societies as to new group purchasers in that area of the Blue Shield plan.

Early preparation and distribution of a physician's manual containing details and forms to be used in connection with the prepaid plans.

"Spring Clinic"

TEACHING PROGRAMS ANNOUNCED

J. W. GALE, M. D.

The Council on Scientific Work, in cooperation with the State Board of Health, the Wisconsin Division of the American Cancer Society, W.A.T.A., the Wisconsin Heart Association, the Wisconsin Chapters of the National Foundation for Infantile Paralysis, the Wisconsin Academy of General Practice, and the two medical schools, announces the following medical teaching programs. Details of the program were planned by a coordinating committee on postgraduate education, with Joseph Gale, M.D., representing the Council on Scientific Work.

Circuit Teaching Program 1:

JANESVILLE ★ STEVENS POINT ★ APPLETON

HOSPITAL "WET CLINICS"

1. APRIL 15–16–17: 7:30–10:30 p.m.

April 15: Mercy Hospital, Janesville
April 16: St. Michael's Hospital, Stevens Point
April 17: St. Elizabeth's Hospital, Appleton

PROGRAM:

"Leukemia," Robert Schilling, M.D., assistant professor of medicine, University of Wisconsin Medical School

"The Problem of Essential Hypertension," Charles Crumpton, M.D., assistant professor of medicine, University of Wisconsin Medical School

FEE: $3.00. No special fee if registered for second "Wet Clinic" on April 29, 30, May 1, and "Spring Clinic" on May 13, 14, 15.

2. APRIL 29–30–MAY 1: 7:30–10:30 p.m.

April 29: Mercy Hospital, Janesville
April 30: St. Michael's Hospital, Stevens Point
May 1: St. Elizabeth's Hospital, Appleton

PROGRAM:

"Treatment of Head Injuries," Theodore C. Erickson, M.D., associate professor (in charge of neurosurgery), University of Wisconsin Medical School

"Surgical Lesions of the Esophagus," Forrester Raine, M.D., associate clinical professor of surgery, Marquette University School of Medicine

FEE: $3.00. No special fee if registered for both "Wet Clinics" and "Spring Clinic" on May 13, 14, 15.

3. MAY 13–14–15: "SPRING CLINIC": 2:00–9:00 p.m. (with dinner)

May 13: Monterey Hotel, Janesville
May 14: Stevens Point (Location to Be Announced)
May 15: Elks Club, Appleton

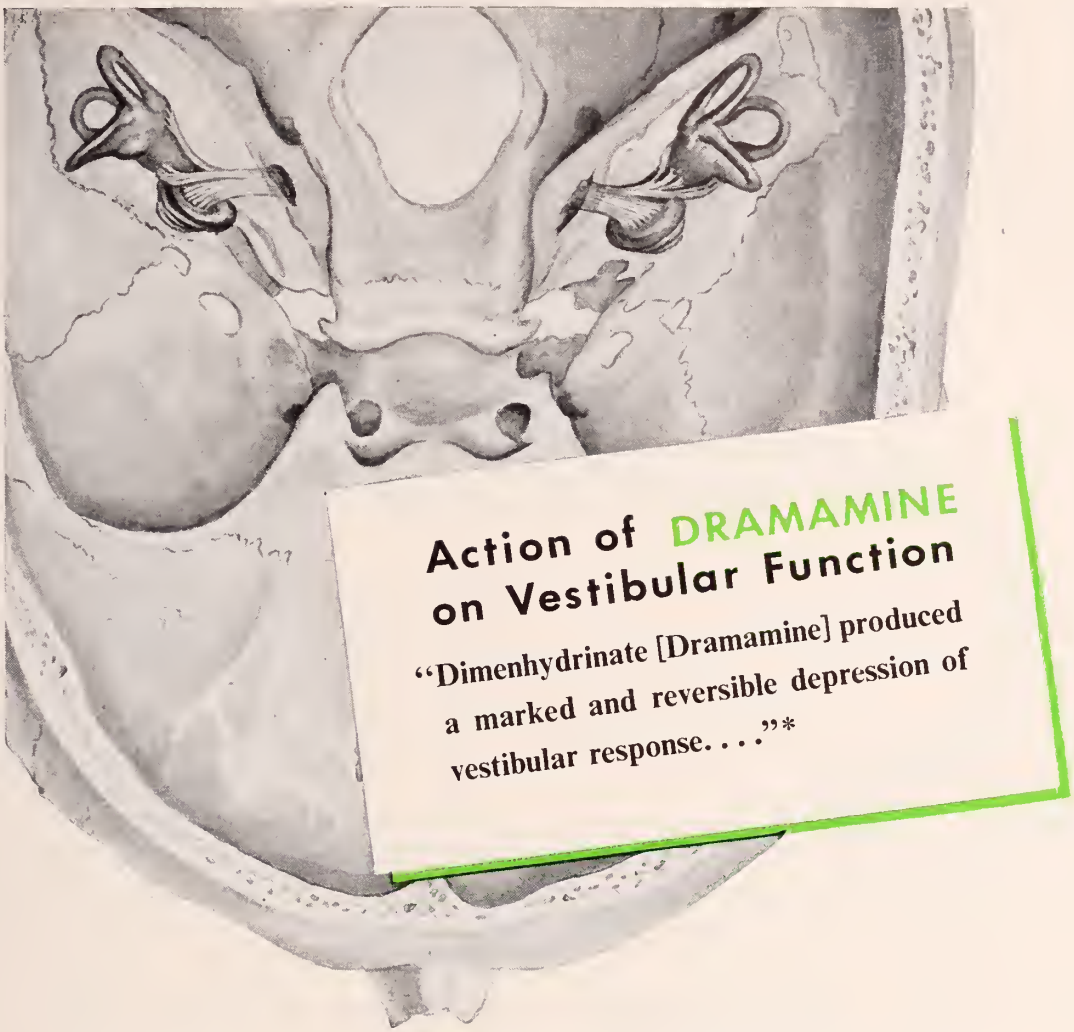
PROGRAM:

Moderator: G. C. Collentine, Jr., M.D., coordinator of postgraduate education, Marquette University School of Medicine

1:30 p.m.: REGISTRATION

2:00 p.m.: Responsibilities of the Obstetrician in the Problem of Prematurity: M. Edward Davis, M.D., Joseph Boliver DeLee professor of obstetrics and gynecology, Chicago Lying-in-Hospital, University of Chicago

2:30 p.m.: Fractures of the Upper and Lower Extremities: Walter Zeit, Ph.D., professor and director of the department of anatomy, Marquette University School of Medicine



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"Dimenhydrinate [Dramamine] produced a marked and reversible depression of vestibular response. . . ."*

In a study of the action of Dramamine on vestibular function, Gutner and his associates found that Dramamine "significantly delayed the onset of nystagmus, shortened the duration of nystagmus and increased the milliamperage necessary to effect tilting."

The great effectiveness of Dramamine in motion sickness, they state, ". . . is probably related primarily to its ability to depress vestibular function. . . ."

DRAMAMINE®

BRAND OF DIMENHYDRINATE

—for prevention and treatment of motion sickness—

Now available in these dosage forms: { Tablets — 50 mg. / Liquid — 12 mg. per 4 cc. / Average dose — 50 mg.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

*Gutner, L. B.; Gould, W. J., and Batterman, R. D.: Action of Dimenhydrinate (Dramamine) and Other Drugs on Vestibular Function, Arch. Otolaryng. *53*:308 (March) 1951.

RESEARCH IN THE SERVICE OF MEDICINE **SEARLE**

Prescribe Journal-advertised products and you prescribe the best.

3:00 p.m.: **Trends in Therapy of Extremity Fractures:** Bruce Brewer, M.D., clinical instructor in orthopedic surgery, Marquette University School of Medicine
3:30 p.m.: **Advances in the Treatment of Tuberculosis:** J. W. Towey, M.D., superintendent and medical director, Pinecrest Sanatorium, Powers, Michigan
4:00 p.m.: 15 Minute Recess
4:15 p.m.: **Limp: A Danger Signal:** Doctor Brewer
4:45 p.m.: **Differential Diagnosis of Chest Diseases:** Doctor Towey
6:00 p.m.: DINNER
7:30 p.m.: **The Perineum:** Doctor Zeit
8:00 p.m.: **Indications and Contraindications for Induction in Labor:** Doctor Davis
8:30 p.m.: Questions of all Speakers

Note: In Stevens Point dinner speakers will be Doctor Brewer and Doctor Towey.

FEE: $6.00 for "Spring Clinic" only. $10 for spring clinic and two hospital conferences.

Circuit Teaching Program 2:

RACINE ★ MARINETTE–MENOMINEE, MICH. ★ SHEBOYGAN

HOSPITAL "WET CLINICS"

1. APRIL 22–23–24: 7:30–10:30 p.m.

April 22: St. Mary's Hospital, Racine
April 23: St. Joseph's Hospital, Menominee, Mich.
April 24: Memorial Hospital, Sheboygan

PROGRAM:

"**Proper Handling of the Premature Infant,**" John Gonce, Jr., M.D., professor of pediatrics, University of Wisconsin Medical School

"**Ankle Fractures,**" Herman W. Wirka, M.D., associate professor of orthopedic surgery, University of Wisconsin Medical School

FEE: $3.00. No special fee if registered for both "Wet Clinics" and for "Spring Clinic" on May 20, 21, and 22.

2. MAY 6–7–8: 7:30–10:30 p.m.

May 6: St. Mary's Hospital, Racine
May 7: St. Joseph's Hospital, Menominee, Mich.
May 8: St. Nicholas Hospital, Sheboygan

PROGRAM:

"**Surgical Diseases of the Colon and Rectum,**" Kenneth Lemmer, M.D., associate professor of surgery, University of Wisconsin Medical School

"**Treatment in Diabetes.**" Bruno J. Peters, M.D., assistant clinical professor of medicine, Marquette University School of Medicine

FEE: $3.00. No special fee if registered for both "Wet Clinics" and "Spring Clinic" on May 20, 21, and 22.

3. MAY 20–21–22: "SPRING CLINICS": 2:00–9:00 p.m. (with dinner)

May 20: Racine Country Club, Racine
May 21: Riverview Country Club, Menominee, Mich.
May 22: Foeste Hotel, Sheboygan

Moderator: E. H. Jorris, M.D., assistant state health officer, Madison

PROGRAM:

1:30 p.m.: REGISTRATION
2:00 p.m.: **Pharmacologic Action of Cardiac Drugs:** O. Sidney Orth, M.D., professor of pharmacology and anesthesiology, University of Wisconsin Medical School
2:30 p.m.: **Therapeutic Use of Cardiac Drugs:** Ovid O. Meyer, M.D., professor of medicine, University of Wisconsin Medical School
3:00 p.m.: **The Diagnosis and Treatment of Hyperthyroidism:** Edmund B. Flink, M.D., associate professor of internal medicine, University of Minnesota Medical School, Minneapolis
3:30 p.m.: **Common Gynecologic Surgical Procedures:** Walter J. Reich, M.D., professor of gynecology, Cook County Graduate School, Chicago
4:00 p.m.: 15 Minute Recess
4:15 p.m.: **Current Drug Additions of Clinical Promise:** Doctor Orth
4:45 p.m.: **The Treatment of the Alkalosis of Vomiting and Other Disturbances of Fluid and Electrolyte Balance:** Doctor Flink
6:00 p.m.: DINNER
7:30 p.m.: **The Anemias:** Doctor Meyer
8:00 p.m.: **Management of Common Gynecologic Office Problems:** Doctor Reich
8:30 p.m.: Questions of all Speakers

Note: In Menominee the dinner speakers will be Doctors Orth and Flink.

FEE: $6.00 for "Spring Clinic" only. $10 for spring clinic and two hospital conferences.

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Circuit Teaching Program 3:

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APRIL 22	APRIL 23	APRIL 24
VFW Post Club House	Northern Hotel	Badger Hotel

Moderator: Robert C. Parkin, M.D., director of postgraduate education, University of Wisconsin Medical School

PROGRAM:

1:30 p.m.: REGISTRATION
2:00 p.m.: **Abnormalities in Growth:** E. S. Gordon, M.D., associate professor of medicine, University of Wisconsin Medical School
2:30 p.m.: **Fractures in Children:** Walter Blount, M.D., Children's Hospital, Milwaukee
3:15 p.m.: **Responsibilities of the Obstetrician in the Problem of Prematurity:** William C. Keettel, associate professor of obstetrics and gynecology, University of Iowa College of Medicine, Iowa City
3:45 p.m.: 15 Minute Recess
4:00 p.m.: **Recent Developments in the Treatment of Heart Disease:** Horace M. Korns, M.D., Iowa City
4:30 p.m.: **Common Disorders of Growing Bone:** Doctor Blount
4:50 p.m.: **Indications and Contraindications for Induction in Labor:** Doctor Keettel, M.D.
6:00 p.m.: DINNER
7:30 p.m.: **Differential Diagnosis of Pain in the Chest:** Doctor Korns
8:00 p.m.: **Danger Signals in the Use of ACTH and Cortisone:** Doctor Gordon
8:30 p.m.: Questions of all Speakers

Note: In Chippewa Falls Doctors Blount and Keettel will be dinner speakers.

FEE: $6.00, including dinner.

Credit for Academy Members

All of the above courses are certified for formal teaching credit for members of the Wisconsin Academy of General Practice.

3 Hours for each of the Hospital "Wet Clinics"
5 Hours for each of the "Spring Clinics"

Registration:

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Entire Series: $10.00
Hospital "Wet Clinics" Only: $3.00 each
Spring Clinic Only: $6.00 (includes dinner)

Where you will attend: Janesville _____, Stevens Point _____, Appleton _____

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Let Us Know What Meetings Your Reservation Covers

CIRCUIT PROGRAM 2: RACINE, MARINETTE–MENOMINEE, MICH., SHEBOYGAN

Entire Series: $10.00
Hospital "Wet Clinics" Only: $3.00 each
Spring Clinic Only: $6.00 (includes dinner)

Where you will attend: Racine _____, Marinette–Menominee, Mich. _____, Sheboygan _____

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Let Us Know What Meetings Your Reservation Covers

CIRCUIT PROGRAM 3: RICHLAND CENTER, CHIPPEWA FALLS, MERRILL

$6.00 (includes dinner). Check where you will attend:

April 22: Richland Center _____ April 23: Chippewa Falls _____

April 24: Merrill _____

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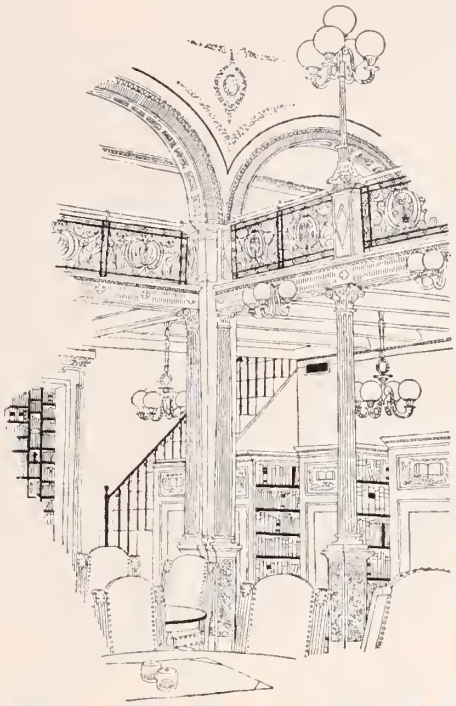

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SOCIETY PROCEEDINGS

Brown–Kewaunee–Door

J. A. KLIEGER

The February meeting of the Brown–Kewaunee–Door County Medical Society was held on February 14 at the Beaumont Hotel in Green Bay. *Dr. Jack A. Klieger*, clinical instructor in obstetrics and gynecology at the Marquette University School of Medicine, was the featured speaker during the scientific portion of the meeting. He chose "The Indications for Induction of Labor" as his subject.

Calumet

A joint meeting of the Calumet County Medical Society and its Auxiliary was held at Leon's Fine Foods in New Holstein on January 31. *Dr. F. G. Hidde*, a Sheboygan surgeon, addressed the group on "Common Injuries of the Wrist." A social hour followed the scientific program.

Green Lake–Waushara

The members of the Green Lake–Waushara County Medical Society met at the Hotel Whiting in Berlin on January 31. The highlight of the meeting was the showing of a sound movie entitled "We'll See Them Through." This movie, which was provided by the State Board of Health, was on the subject of rheumatic fever.

Jefferson

Meeting at Chauncey's in Pipersville on January 17, the members of the Jefferson County Medical Society heard an address by *Dr. F. Jackson Stoddard*, assistant clinical professor of obstetrics and gynecology at the Marquette University School of Medicine. His subject was "Endocrine Therapy in Gynecology." During the business session, *Dr. W. H. Costello*, of Beaver Dam, councilor of the First District, explained the need for the increase in State Society dues.

Dr. Ovid O. Meyer, professor and chairman of the department of medicine of the University of Wisconsin Medical School, was the featured speaker at the February 21 meeting of the Society, which was held in Jefferson at Radtke's Tea Room. Doctor Meyer's talk was on the subject of arthritis.

Kenosha

The members of the Kenosha County Medical Society were the guests of the Kenosha County Home in Kenosha on February 7. The two invited speakers for the evening were Mr. J. P. Newhouse, head of the pension department, and Mr. A. S. Nielsen, head of the welfare department of Kenosha County. The gentlemen gave short talks on the operation of their departments and a general discussion period followed.

Oneida–Vilas

Dr. C. M. Yoran, of Wausau, director of Mt. View Sanitorium, addressed the January 23 meeting of the Oneida–Vilas County Medical Society, which was held at the Al–Gen Dinner Club in Rhinelander. "Recent Changes in Tuberculosis Therapy," illustrated by films, was the subject chosen by Doctor Yoran.

Richland

Dr. J. I. Spear was elected president of the Richland County Medical Society at the annual business meeting held on January 31. Other officers elected were *Drs. W. C. Edwards*, vice president; *L. M. Pippin*, secretary-treasurer; *D. H. Hinke*, delegate; *R. E. Housner*, alternate delegate; and *K. H. Meyer*, Doctor Pippin, and *D. J. Taft*, board of censors. All of the officers are from Richland Center.

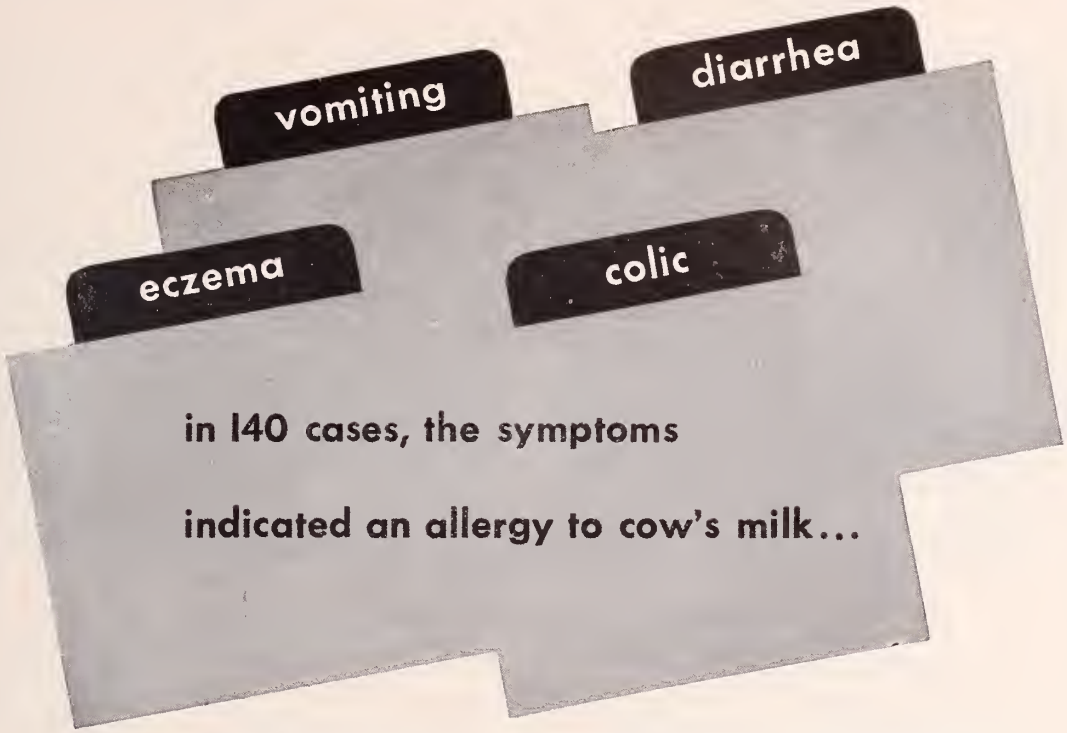
Sheboygan

At a recent meeting of the Sheboygan County Medical Society, the following officers were elected for 1952:

President—*Dr. John E. Martineau*, Elkhart Lake
Vice–President—*Dr. Roman C. Pauly*, Sheboygan
Secretary–Treasurer—*Dr. J. F. Hildebrand*, Sheboygan
Censor—*Dr. C. C. Gascoigne*, Kohler
Dr. Ludwig Gruenewald, Sheboygan
Delegate—*Dr. Paul B. Mason*, Sheboygan
Alternate Delegate—*Dr. F. A. Nause*, Sheboygan

American Academy of General Practice Fond du Lac Chapter

The Fond du Lac Chapter of the American Academy of General Practice met at the 101 Club in Fond du Lac on February 7. The program for the evening was something different in medical society meetings, in that the speaker, *Dr. Karl K. Borsack*, Fond du Lac, chose as his subject the life of Lincoln. His talk was illustrated by colored slides which he had made himself.



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*Clein, Norman W.: Cow's Milk Allergy in Infants, Ann. Allergy 9:195 (March-April) 1951.

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Winnebago

N. O. BECKER

Dr. Norman O. Becker, Fond du Lac, was the guest speaker at the February 7 meeting of the Winnebago County Medical Society. Addressing the members of the Society at the Menasha Hotel, Menasha, Doctor Becker chose "Surgical Aspects of the Chest" as his topic.

Wood

Dr. Elmer E. Debus, Wisconsin Rapids, was elected president of the Wood County Medical Society at a meeting held January 31 at the Hotel Mead in Wisconsin Rapids. *Dr. J. S. Vedder*, Marshfield, was elected vice president. The following officers were re-elected to serve in 1952: *Drs. R. W. Mason*, Marshfield, secretary–treasurer; *R. E. Garrison*, Wisconsin Rapids, delegate; and *K. H. Doege*, Marshfield, alternate delegate.

Two papers were presented by members of the society during the scientific portion of the program. *Dr. T. J. Rice*, Marshfield, discussed "Post-Maturity in Infants," and *Dr. E. G. Barnet*, Wisconsin Rapids, chose "New Trends and Aspects of Allergy" as his topic.

News Items and Personals

Avoca Physician Honored

Dr. Bertha E. Reynolds of Avoca, formerly of Lone Rock, was recently honored by the citizens of Lone Rock when a memorial forest was named in her honor. The resolution to honor the doctor reads in part:

"Whereas the original idea of creating a beautiful pine forest out of abandoned waste land was conceived by Dr. Bertha E. Reynolds of Avoca, Wisconsin, who has worked untiringly for many years for the accomplishment of the project.

"Now, Therefore, Be It Resolved that the reforestration area owned by Sauk County in the southwestern portion of the county and recently planted to create a pine forest be and the same shall hereafter be known as the 'Dr. Bertha E. Reynolds Memorial Forest.'"

Doctor Gouze Addresses Rotary Club

Dr. F. J. Gouze, Marshfield physician, addressed the February 11 meeting of the Marshfield Rotary Club on the subject of heart disease. Doctor Gouze, whose talk was timed for Heart Week, told the Rotary Club that the heart campaign was worthy of support. He pointed out that although this campaign does not have the same dramatic appeal as the polio drive, the death rate from heart trouble is 12 times as great as the polio death rate in Wisconsin.

Dr. W. R. McInnis Opens Office in Marion

Dr. W. R. McInnis, formerly of Antigo, has established his practice in Marion. A native of Eau Claire, the doctor received his medical degree from Marquette University School of Medicine in 1950 and served his internship at Milwaukee County General Hospital.

Dr. R. R. Davis Moves to New Richmond

Dr. R. R. Davis recently became associated with the New Richmond Clinic, New Richmond. Doctor Davis had formerly practiced in Shell Lake and also in River Falls. He received his medical degree from St. John's University in Shanghai, China and served his internship and residency at Wisconsin General Hospital, Madison.

Rice Clinic Has New Associate

Dr. F. W. Reichardt has joined the staff of the Rice Clinic in Stevens Point. A 1943 graduate of the University of Wisconsin Medical School, the doctor served for four and one-half years in the Navy Medical Corps during World War II. He practiced in Stevens Point from 1947 to 1948 and then joined the staff of Wisconsin General Hospital, Madison, for a three year residency in orthopedics.

Pediatrician Addresses Parent Group

Dr. E. H. Pawsat, a Fond du Lac pediatrician, addressed the January 21 meeting of the Green Lake Parent–Teachers Association. The doctor stated that the results of assembly line physical examinations of school children were frequently disappointing and urged a more individualized contact between the child and the physician.

Doctor Hogan Moves to Virginia

Dr. John Hogan, who has practiced in Pepin for the past eight years, recently closed his office to move to Bigstone Gap, Virginia, where he will continue in industrial and private practice. A graduate of the University of Chicago, The School of Medicine, he served his internship at Cook County and St. Bernard Hospitals, Chicago.

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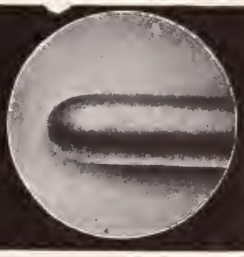

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Physician Joins Clinic Staff

Dr. John Noble, who formerly practiced in Amery, has joined the staff of the Krohn Clinic and Hospital in Black River Falls. Doctor Noble is a graduate of the University of Illinois College of Medicine and served his internship and residency at the Augustana Hospital, Chicago.

Three Specialists Begin Practice in Sheboygan

Dr. J. W. Bringe, former instructor in dermatology at the University of Michigan Medical School, recently opened an office in Sheboygan to practice in his specialty. A native of Milwaukee, the doctor is a graduate of the University of Wisconsin Medical School and served his internship at Columbia Hospital, Milwaukee. He did postgraduate work in dermatology at the University of Wisconsin and also at the University of Michigan.

Dr. J. J. Van Driest, a 1946 graduate of the University of Wisconsin Medical School, has opened an office in Sheboygan and will specialize in orthopedic surgery. He served his internship at Columbia Hospital, Milwaukee, and completed a three year residency in orthopedic surgery at Columbia Hospital and Milwaukee Children's Hospital.

Dr. Robert A. Wood, former chief of the urology section of the Minneapolis Veterans' Hospital, joined the staff of the Sheboygan Clinic last November. Doctor Wood received his medical training at the University of Minnesota, graduating in 1944. He served in the U. S. Army Medical Corps for two years.

Dr. B. C. Hindall Now Associated With Dr. D. H. Jeffers

Dr. Boyd C. Hindall, who recently completed service in the Army Medical Corps, became the associate of *Dr. D. H. Jeffers,* Lake Geneva, last November.

Doctor Hindall's army assignment included work in Japan and Korea. While in the latter, he was in command of the Twenty-Fifth Infantry Division clearing company. He is a graduate of the Washington University School of Medicine.

Two Physicians Attend Postgraduate Courses

Dr. Otto A. Backus, Wisconsin Rapids, and *Dr. Louis Milson,* Green Bay, are attending postgraduate courses at the Cook County Graduate School of Medicine, Chicago. Doctor Backus is a graduate of the University of Wisconsin Medical School, and Doctor Milson received his medical degree from Marquette University School of Medicine.

Two Hospitals Elect Staff Officers

Dr. R. J. Dietz, Waterford, was recently elected chief of staff of the Burlington Memorial Hospital. Others elected to serve with him are *Drs. W. D. Haedike,* Union Grove, vice chief; and D. J. Baker, Burlington, secretary–treasurer.

At a meeting of the staff of St. Agnes Hospital, Fond du Lac, *Dr. L. C. Gardner* was appointed chief of staff. *Dr. R. L. Waffle* will serve as secretary and *Drs. R. W. Steube, E. V. Smith,* and *J. C. Yockey* will serve on the executive committee. All of the officers are from Fond du Lac.

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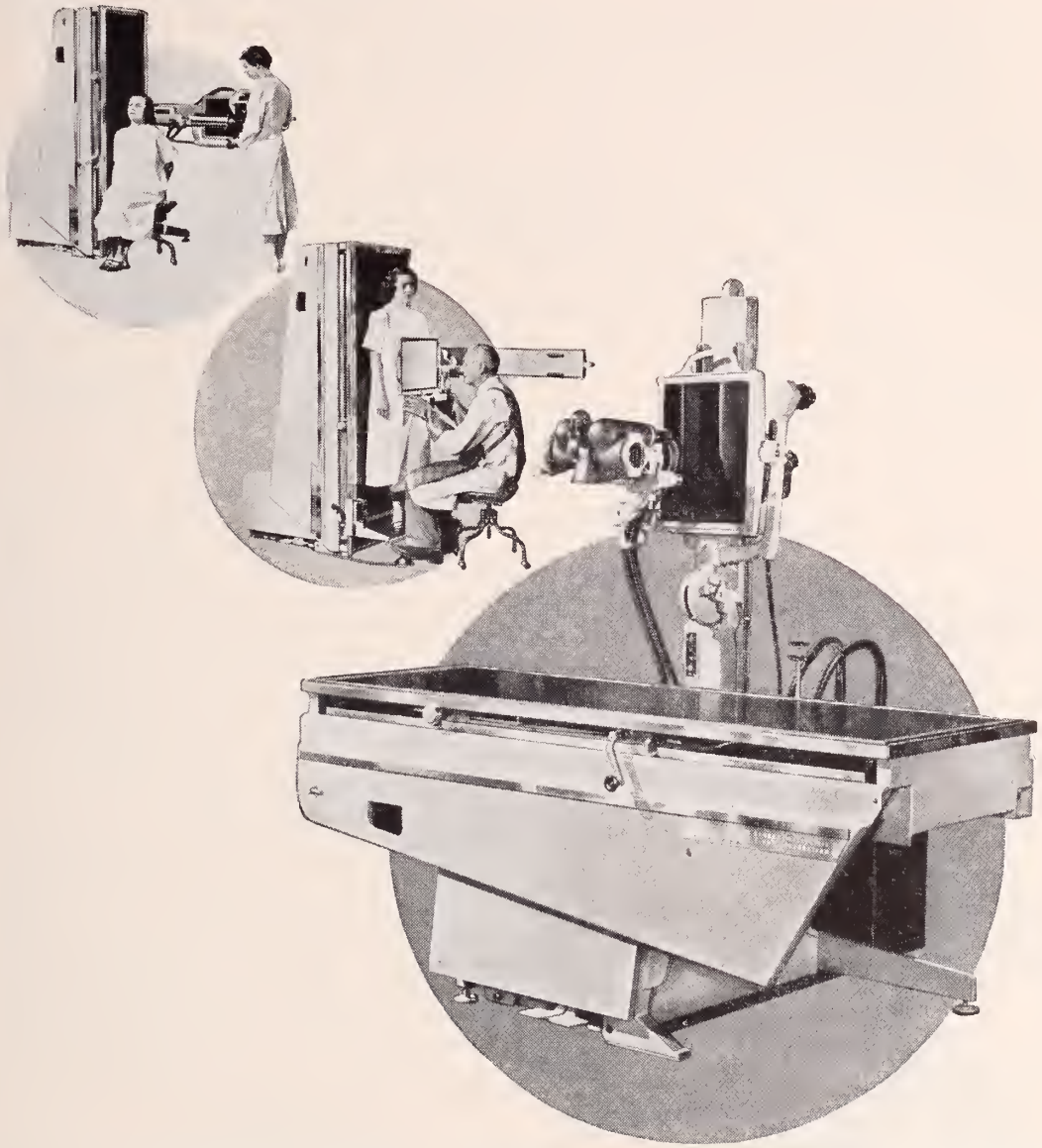

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THIRD AND TWELFTH DISTRICT NEWS

Dr. W. B. Youmans Appointed to U. W. Post

Dr. William B. Youmans was recently appointed to the post of chairman of the department of physiology of the University of Wisconsin Medical School. He will replace Dr. J. A. E. Eyster, present head of the department, who is retiring. Doctor Youmans, who comes to the University from a similar post at the University of Oregon, received his Ph.D. in physiology from the University of Wisconsin and earned his M. D. degree at the University of Oregon.

Doctor Parkin Addresses Two Groups

Dr. Robert C. Parkin, co-ordinator of postgraduate medical education at the University of Wisconsin, addressed a meeting of the Eau Claire Woman's Club on January 29. Speaking on "Eating Your Life Away," he explained the connection between over-weight and high blood pressure. Doctor Parkin also recently addressed the Roosevelt Parent-Teacher Association, Janesville. On this occasion the subject of his talk was "Psychosomatic Illnesses."

Pember–Nuzum Clinic Has New Staff Member

Dr. Stephen M. Chasten, orthopedic surgeon who was recently released from the U. S. Army Medical Corps, has become associated with the Pember-Nuzum Clinic in Janesville. Doctor Chasten was graduated from the University of Illinois College of Medicine in 1939 and served his internship at St. Mary's Hospital, Madison. He received his orthopedic training at Northwestern University.

Doctor Nelson Addresses Hospital Auxiliary

Dr. Pierce D. Nelson, director of the bureau of tuberculosis control of the State Board of Health, was the guest speaker at the February 21 meeting of the Oconto Hospital Auxiliary. Doctor Nelson, who is a former Oconto physician, addressed the group on the tuberculosis program in Wisconsin.

U.W. Medical School Announces New Appointees

Eleven members of the staff of the Madison Veterans Administration Hospital were recently appointed assistant clinical professors of the University of Wisconsin Medical School. Appointed were Drs. *R. N. Allin, M. A. Foster, A. J. Richtsmeier, A. B. Weinstein,* and *J. M. Wilkie,* department of medicine; *B. I. Brindley,* otolaryngology; *F. G. Joachim,* surgery; *P. R. Kundert,* urology; *S. C. Rogers,* orthopedic surgery; *H. M. Suckle,* neurosurgery; and *W. C. Lewis,* neuropsychiatry.

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Pediatrician Opens Office in Madison

Dr. Charles E. Hopkins, former pediatrician on the staff of the Quincy, Ill., Clinic recently opened an office for the practice of pediatrics in Madison. A native of Syracuse, N. Y., Doctor Hopkins was graduated from the Syracuse University College of Medicine and interned at Chelsea Naval Hospital, Chelsea, Mass. He served his residency at Massachusetts General Hospital, Boston, and at Johns Hopkins Hospital, Baltimore, Md.

Plastic Surgeon Addresses Janesville Group

Automobile and industrial accidents account for a large part of the plastic surgery which is done today, *Dr. F. D. Bernard,* Madison plastic surgeon, stated at the February 3 meeting of the Janesville Kiwanis Club. Doctor Bernard's talk on the subject "Recent Advances in Plastic Surgery" was illustrated with slides showing some of the excellent results accomplished in his specialty.

Doctor Hartenstein Stationed on Okinawa

Dr. Hans Hartenstein, former resident in pediatrics at the State of Wisconsin General Hospital, Madison, is now serving in the U. S. Army Medical Corps and is stationed in Okinawa. He also was stationed for several months in Tokyo and Hiroshima, Japan. A 1947 graduate of the University of Wisconsin Medical School, Doctor Hartenstein served his internship at Mount Sinai Hospital, Chicago.

Sauk

Mr. A. W. Gaarter of the firm of Gaarter and Miller, Madison, addressed the February 12 meeting of the Sauk County Medical Society at the Warren Hotel in Baraboo. Mr. Gaarter's subject was "Medical Economics." During the business session, *Dr. E. V. Stadel,* president of the Society announced the appointments to the standing committees for 1952.

Columbia Hospital Has New Chief of Staff

J. L. GARVEY

Dr. J. L. Garvey was appointed chief of staff of the Columbia Hospital, Milwaukee, on February 12. He replaces *Dr. F. W. Madison,* associate clinical professor of medicine at Marquette University School of Medicine, who retired after holding the position since 1941. Doctor Garvey is head of the Marquette University School of Medicine division of neurology.

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Dr. L. L. Larsen Awarded Citation by U. S. Army

Dr. L. L. Larsen, former Hales Corners and Campbellsport physician, and who is now serving in the U. S. Army Medical Corps at Ft. Hood, Texas, has been awarded a certificate of achievement by his divisional surgeon for quick action which saved the life of a soldier bitten by a black widow spider. The citation which accompanied the certificate read in part, "Lieutenant Larsen showed courageous action and displayed exemplary professional skill in his deed."

Milwaukee Psychiatrist Addresses Group

Dr. J. R. Altmeyer, staff psychiatrist at the Milwaukee County Guidance Clinic addressed the January 28 meeting of the Association for the Education of the Mentally Handicapped Child at the Goodwill Industries in Milwaukee. The doctor's subject was "Psychiatric Concepts and Mental Deficiency."

Milwaukee

The members of the Medical Society of Milwaukee County met in a joint session with the Wisconsin Heart Association on February 14 at the Milwaukee Athletic Club. The scientific program was devoted to a Symposium on Hypertension, which was presented by three medical scientists widely known for research in phases of heart disease. Oscar M. Helmer, Ph.D., head of the department of clinical biochemistry of the Lilly Laboratory for clinical research at the Indianapolis General Hospital, opened the symposium with a paper entitled "Background for Medical and Surgical Management of Hypertension." He was followed by Dr. Henry A. Schroeder, associate professor of medicine at the Washington University Medical School, whose subject was "Medical Management of Hypertension." Dr. Reginald H. Smithwick, professor of surgery at Boston University Medical School, closed the program with a paper on "The Surgical Management of Hypertension."

Milwaukee Academy of Medicine

The members of the Milwaukee Neuropsychiatric Society were guests at the February 19 meeting of the Milwaukee Academy of Medicine. The Arthur W. Rogers Memorial Lecture was presented by Dr. L. M. Eaton, consultant in neuropsychiatry of the Mayo Clinic and professor of neuropsychiatry at the Mayo Foundation. The subject of Doctor Eaton's address was "Myasthenia Gravis."

Milwaukee Oto-Ophthalmic Society

"Management of Tumors of the Larynx" was the subject of a talk by Dr. P. H. Hollinger, Chicago, at the Feb. 26 meeting of the Milwaukee Oto-Ophthalmic Society. *Dr. C. H. Kalb*, Milwaukee, presented a paper on "Periorbital Dermatosis."

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A. E. Talbot, 332 West Seymour Street, Appleton.

Stella I. Burdette, Balsam Lake.

G. W. Zauft, Medical Arts Building, Prairie du Sac.

L. T. Schlenker, 723 Fifty-eighth Street, Kenosha.

R. W. Way, 105 North Lincoln Avenue, Beaver Dam.

W. F. Brown, 925 Mound Street, Madison.

M. J. Talbert, 6 South Hillside Terrace, Madison.

J. W. Bringe, 804 Michigan Avenue, Sheboygan.

F. F. Nelson, Colby.

J. W. Shaw, 1117 North Eighth Street, Manitowoc.

G. D. McAfee, Suite 307, 218½ South Barstow Street, Eau Claire.

F. A. Brei, 51½ West New York Avenue, Oshkosh.

W. V. Hahn, 11 Algoma Avenue, Oshkosh.

J. E. Leach, 1545 South Layton Blvd., Milwaukee.

S. E. Sivertson, 1836 South Avenue, La Crosse.

B. S. Schaeffer, 4520 North Wilson Drive, Milwaukee.

Changes in Address

Hans Hartenstein, Milwaukee, to 01921164, Ryukyus Army Hospital, 8114th A.U., APO 719, % Postmaster, San Francisco, California.

A. M. Kohn, Milwaukee, to A01912515, 314 Medical Group, Sewart Air Force Base, Tennessee.

P. J. Sanfilippo, Racine, to 651 Leonard Avenue, East Hempstead, Long Island, New York.

L. H. Lokvam, Kenosha, to River Pines Sanatorium, Stevens Point.

Morris Mitz, Milwaukee to 28 Burgess Court, Sumter, South Carolina.

John Hogan, Pepin, to Big Stone Gap, Virginia.

R. D. Johnson, Ann Arbor, Michigan, to Mercy Hospital, 700 Empire Building, Benton Harbor, Michigan.

C. P. Haseltine, New York, New York, to 46 Washington Boulevard, Oshkosh.

W. T. Russell (MC), Minneapolis, Minnesota, to 4886 Keswick Court, Chamblee, Georgia.

E. J. Hohler, Mineral Point, to 02096461, Stud. Det., Class 8-0-2, M.F.S.S., Fort Sam Houston, San Antonio, Texas.

A. L. Curtin, Milwaukee, to 239 N. E. Eleventh Street, Delray Beach, Florida.

G. S. Riegel, St. Croix Falls, to 710 Seventh Street, Minneapolis, Minnesota.

Y. B. Sutch, Lake Geneva, to 19324 Callier, Box 398, Tarzana, California.

J. K. Olinger, Waukesha, to 6014 A. S. V., Camp Cook, California.

Salvatore Megna, Milwaukee, to 1938 East Kleindale, Tucson, Arizona.

H. E. Oppert, Madison, to 854 Clower Street, San Antonio, Texas.

DEATHS

Dr. George E. Thill, 46, Milwaukee physician, died in an airplane accident on January 5. Doctor Thill, accompanied by three of his four children, was piloting his own plane on the return trip from a vacation when the plane disappeared into Lake Michigan.

Born in Fosston, Minn. on May 21, 1905, the doctor took his premedical studies at the University of Wisconsin and received his medical degree from Marquette University School of Medicine in 1931. He interned at St. Joseph's Hospital and after a brief period of practice at Manitowoc, he established his practice in Milwaukee. He was a member of the staff and formerly chief of staff at St. Anthony's Hospital and was a visiting staff member of Deaconess Hospital.

Doctor Thill held a commercial pilot's license and actively participated in the civil air patrol during World War II. He and Mrs. Thill were both teachers at Mount Mary College, the doctor teaching physics and aeronautics, and his wife teaching occupational therapy. The doctor also taught aeronautics at Milwaukee State Teachers' College.

Doctor Thill was a member of the Medical Society of Milwaukee County, the State Medical Society, and the American Medical Association.

Survivors include Mrs. Thill and a daughter.

B. J. HUGHES

Dr. Byron J. Hughes, 47, one of the outstanding men in the state in the field of psychiatric medicine and superintendent of Winnebago State Hospital, died suddenly in an Oshkosh hospital on January 15. He was born in Wyocena on April 28, 1904.

A 1931 graduate of the University of Wisconsin Medical School, the doctor interned at Milwaukee County General Hospital. He joined the staff of Winnebago State Hospital in 1933 as senior physician, clinical director, and assistant superintendent. He was appointed superintendent in November 1939. Doctor Hughes was also a consultant to the staffs of Alexian Brothers and Mercy Hospitals, Oshkosh, and served on the executive council of the Mercy Hospital School of Nursing.

He was chairman of the medical advisory committee of the Veterans Recognition Board and was a member of the committee on veterans affairs of the State Medical Society. In 1950 he was elected vice-speaker of the House of Delegates of the State Medical Society and elected Speaker of that body in 1951.

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The use of simple laboratory tests (sedimentation rates, urinalyses, blood counts, blood pressure, and frequent weight recordings), individualized adjustment of dosage, and careful clinical observation will permit most patients to benefit materially . . . without fear of undesired effects.

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Effective antirheumatic response was achieved in all 100 patients in a long-term study at the Mayo Clinic. More than 50 of these arthritics were maintained on 50 mg. or less daily. In no case was it necessary to withdraw the hormone.

Ward, L. E., Slocumb, C. H., Polley, H. F., Lowman, E. W., and Hench, P. S.: *Proc. Staff Mtgs., Mayo Clinic* 26: 361, September 26, 1951.

Literature on Request

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Therapy for Vascular Headache to Reverse the Physiologic Disturbance

Headache, a problem encountered in all kinds of medical practice, may occur in association with any of a variety of disorders, some organic, other purely functional.

Among the several types, functional headaches present the greatest problem because of their obscure etiology and recurrent nature.

Among these are:

Migraine (both classical and variant forms)
Tension headache
Psychogenic headache
Histaminic cephalgia

Wolff and his co-workers established that the pain of these headches is due to disturbance of the tonus of cranial blood vessels — hence the term *vascular headaches.*

The craniovascular changes associated with the several phases of the typical migraine attack are:

Vasoconstriction — to which the visual prodromata are attributable. It is possible to abort the attack during this phase in all but a few cases. (See treatment below.)

Vasodilatation — as the vessels lose their tone, exaggerated pulsations set in, resulting in the throbbing pain which characterizes vascular headache. Treatment for the attack is still effective during this phase. (See below.)

Vessel Edema — if the vasodilation continues for too long, vessel walls become edematous; this changes the character of the pain to a steady, intense aching. The attack can now no longer be checked, even with maximum dosage of specific drugs. *Moreover, sustained headache often induces reflex neck muscle tension, a source of residual pain.*

Therapy: 1. Reduce the frequency of attacks — psychotherapy and regulation of living habits to avoid fatigue and nervous tension.

2. Relieve the acute attack — of the numerous drugs which have been tried, ergotamine and its derivative preparations have proved most effective. The newest product is oral tablets of Cafergot®, N. N. R. (ergotamine with caffeine 'Sandoz'). When dosage is adjusted to the needs of the individual, Cafergot will give good relief in 85% of cases. It enables a greater number of patients to benefit from early administration since the oral route simplifies treatment as compared to parenteral therapy.

The dosage procedure is:

1. Take 2 tablets at first sign of the attack.
2. If attack continues, take one additional tablet every ½ hour until attack is terminated *(max. 6 tabs. per attack).*

Many migraine patients delay taking medication until the attack is at its height. Explicit dosage instructions may be forgotten unless the patient comes to realize their importance. Therefore, to encourage adherence to correct procedure, we have prepared pads outlining detailed dosage instructions. Supplies of these INSTRUCTION SLIPS will gladly be sent upon request.

GENERAL REFERENCES: DeJong, R.: Chicago M. Soc. Bull *54:* 106, 1951. Friedman, A.: Modern Headache Therapy, St. Louis, C. V. Mosby Co., 1951. Wolff, H.: Headache and Other Head Pain, N. Y., Oxford Univ. Press, 1948.

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Doctor Hughes was a diplomate of the American Board of Psychiatry, as well as a member of the Milwaukee Neuropsychiatric Society, the American Psychiatric Association, the American Society on Mental Deficiency, the National Society of Mental Hygiene, the Wisconsin Anti-Tuberculosis Association, the Winnebago County Medical Society, the State Medical Society, and the American Medical Association.

He is survived by his wife, two sons, and two daughters.

Dr. Brand Starnes, 69, died at his home on January 16, following a short illness. He was born in Asheville, North Carolina on May 26, 1882.

The doctor was a graduate of Bingham's Military School, Asheville, N. C., and of the University of North Carolina. He received his medical degree in 1907 from Northwestern University Medical School. He served his internship at Englewood Hospital, Chicago, and practiced in Mauston for 10 years before moving to New Lisbon. He was recently honored by the residents of New Lisbon and the surrounding area when a "Doc Starnes Day" was celebrated on October 7.

A veteran of World War I, Doctor Starnes was a former commander of the D.W.K. Post 110 (New Lisbon). During World War I he served on the Selective Service Board of Juneau County, and he was appointed to the District Examining Board by Governor Heil during World War II. Active in the civic affairs of his city, the doctor was treasurer for the New Lisbon School Board for 15 years. He also was on the staffs of hospitals in La Crosse and Sparta. He served on the Milwaukee Roads medical staff for 30 years and was a member of the American Association of Railway Surgeons.

He was a member of the Juneau County Medical Society, the State Medical Society and the American Medical Association.

His wife survives.

Dr. E. J. Mitchell, retired Brodhead physician, died suddenly on January 26, while in Sarasota, Florida. He was 79 years old.

Born on December 30, 1872, the doctor established his practice in Brodhead following his graduation from Northwestern University Medical School in 1903. He was active in that city until his retirement on November 1, 1946. He served as railroad surgeon for the Milwaukee Road from 1906 until 1946 and also served the city of Brodhead as health officer for 25 years.

Doctor Mitchell is survived by his wife and two sons.

Dr. Lyder O. Gulbrandsen, 52, Viroqua physician, died January 27 in a La Crosse hospital following a long illness.

Born on April 5, 1900 in Westby, the doctor received his medical degree from Marquette University School of Medicine, graduating in 1926. He served his internship at St. Mary's Hospital, Mil-

waukee, and then established his practice in the Westby–Viroqua area.

A veteran of both World Wars, Doctor Gulbrandsen was a member of the Vernon County Medical Society, the State Medical Society, and the American Medical Association.

Survivors include his wife, six sons, and three daughters.

Dr. Archibald J. Hood, 60, a Milwaukee urologist since 1920, died suddenly on February 9. He was born on January 23, 1892.

A 1918 graduate of the Jefferson Medical College of Philadelphia, the doctor served his internship at St. Agnes Hospital, Philadelphia, and his residency at Long Island College Hospital, Brooklyn, New York.

In 1933 he was elected chief of staff of the Milwaukee Hospital and at one time was chief genitourinary surgeon at Milwaukee County General Hospital. A member of the Wisconsin Urological Society, Doctor Hood also held membership in the Medical Society of Milwaukee County, the State Medical Society, and the American Medical Association.

Survivors include his wife, two sons, and a daughter.

Dr. William Ackermann, 76, recently retired Milwaukee physician, died in a Milwaukee hospital on January 26, following a short illness. He was born on April 26, 1875.

An 1896 graduate of the Milwaukee College of Physicians and Surgeons, Doctor Ackermann took postgraduate work in Berlin and Vienna. For a short time he practiced in Germantown and Cedarburg before establishing his permanent practice in Milwaukee in 1903. He was a past member of the staff of St. Joseph's Hospital.

In addition to membership in the National Gastroenterological Society, the doctor was a member of the Medical Society of Milwaukee County, the State Medical Society, and the American Medical Association.

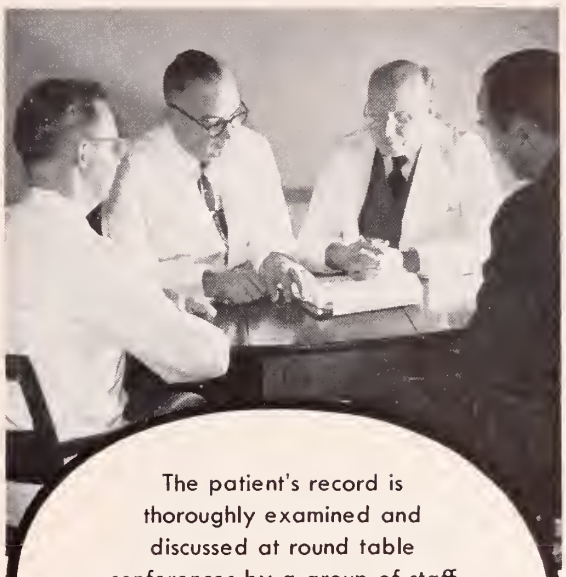
Survivors include his wife, and two daughters.

Dr. Phillip Leicht, retired Lake Mills physician, died in a Milwaukee hospital on February 7, following a long illness. He was 69 years old.

Born in Germantown on May 5, 1882, the doctor taught school for two years before deciding to study medicine. He received his medical degree from the University of Illinois College of Medicine in 1907 and served one year internships at the Englewood Hospital, Chicago, and the Oak Park Hospital, Oak Park, Illinois. He began his practice in Lake Mills in 1909 and continued to practice there until his retirement in 1941, except for the period from 1918 to 1919 when he served as a medical officer during World War I.

Doctor Leicht was a member of the Jefferson County Medical Society, the State Medical Society, and the American Medical Association.

Surviving are his wife and a daughter.



The patient's record is thoroughly examined and discussed at round table conferences by a group of staff members which includes at least two physicians and one counselor.

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CORRESPONDENCE

Milwaukee 2, Wisconsin
December 15, 1951

To The Editor

Dear Sir:

The article on "The Effect of Ammonium Chloride in Epilepsy" by Fritz Kant, M.D., and Warren E. Gilson, M.D., in the November, 1951, issue is of considerable interest, particularly since the results are claimed to be very good. The authors will be interested to know that there is a voluminous literature on the use of acidosis in the treatment of epilepsy and that the use of ammonium chloride is quite well-known. Extension studies have been made of the chemical effect of ammonium chloride on the acid-base metabolism in the human and particularly in the epileptic patient.

The literature on this subject is quite extensive. I reported to the New York Academy of Medicine in March, 1928, that the chemical acidosis produced by the administration of ammonium chloride in large amounts had no favorable effect on the convulsions of epilepsy. In the J.A.M.A. for June 11, 1927, I reported a review of the literature on the effects of fasting and starvation, and also reported that acidosis alone was not sufficient to influence the convulsions of epilepsy. In The WISCONSIN MEDICAL JOURNAL, March, 1932, I made reference to Lennox' article published in 1928 and to another published in 1931 calling attention to the fact that ammonium chloride, calcium chloride and ammonium nitrate did not control the seizures of epilepsy. In The AMERICAN JOURNAL OF PSYCHIATRY, May, 1936, the statement was also made that acidosis produced by chemical means had no effect on the convulsive seizures of epilepsy whether used in conjunction with other forms of treatment or not.

Yours truly,
/s/ M. G. PETERMAN, M. D.

The above letter was referred to the authors of the article mentioned, who replied as follows:

The University of Wisconsin
State of Wisconsin General Hospital
Department of Neuro-Psychiatry
Madison 6

January 9, 1952

To the Editor

Dear Sir:

We wish to thank Dr. Peterman for calling our attention to the excellent and comprehensive paper by Drs. Lennox and Cobb in *Medicine*, 1928, pp. 105–290, "Epilepsy—From The Standpoint of Physiology and Treatment".

Dr. Peterman in his article in the *Wisconsin Medical Journal*, March 1932, referred to the results which they obtained with chemical acidifying agents as follows:

"Lennox has obtained marked temporary reduction in the frequency of seizures with NH_4Cl, $CaCl_2$, and NH_4NO_3. Continued use of the salts a week or more, however, resulted in a recurrence and an increase in the number of seizures." This could give the impression that each of the above chemicals had been tried over a period of many days and found to be unsatisfactory. Such an inference might well be obtained from their brief summary on page 247. An examination of the graphs on the 4 patients given these chemicals shows that the one patient who had a recurrence of seizures with great frequency after treatment had been given $CaCl_2$, not NH_4Cl. Another patient had been on a high fat diet: "On the twenty ninth day of ketosis she had a status of small spells which disappeared a few hours after the ingestion of ammonium chloride." The remaining two patients appear to have been benefited by ammonium chloride also, a reduction from 90 to 6 seizures per day being obtained in one case, 15 to 2 in the other.

The anticonvulsant effect of NH_4Cl and its practical utility were probably ignored because it was considered only as one of a group of chemical acidifying agents, some of which appeared to be therapeutically without value.

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Surgical Technic, Surgical Anatomy & Clinical Surgery, Four Weeks, starting March 3, June 2.
Surgical Anatomy & Clinical Surgery, Two Weeks, starting March 17, June 16.
Surgery of Colon & Rectum, One Week, starting March 3, April 7.
Personal Course in General Surgery, Two Weeks, starting April 14.
Gallbladder Surgery, Ten Hours, starting April 21.
Basic Principles in General Surgery, Two Weeks, starting March 31.
Breast & Thyroid Surgery, One Week, starting June 23.
Esophageal Surgery, One Week, starting June 23.
Thoracic Surgery, One Week, starting June 2.
Fractures & Traumatic Surgery, Two Weeks, starting June 16.
GYNECOLOGY—Intensive Course, Two Weeks, starting March 17, April 21.
Vaginal Approach to Pelvic Surgery, One Week, starting March 31, May 5.
OBSTETRICS—Intensive Course, Two Weeks, starting April 7, June 2.
PEDIATRICS—Intensive Course, Two Weeks, starting April 7.
Informal Clinical Course, every two weeks.
Cerebral Palsy, Two Weeks, starting July 7.
MEDICINE—Intensive General Course, Two Weeks, starting May 5.
Hematology, One Week, starting June 16.
DERMATOLOGY—Intensive Course, Two Weeks, starting May 5.
UROLOGY—Intensive Course, Two Weeks, starting April 28.
Ten Day Practical Course in Cystoscopy starting March 17, March 31, April 14.

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The Medcotronic Stimulator, Model 50, operates on 110 volt, 50 to 60 cycle alternating current. The current generated by the apparatus is non-sinusoidal alternating current. Output circuits have no direct connection to the power supply. The maximum voltage output is from 15 to 18 volts R.M.S.

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Dr. Peterman in his letter indicates that he has in several papers stated that ammonium chloride and chemical acidosis in general have no effect on the convulsive seizures of epilepsy. Again quoting Lennox and Cobb, "The striking thing in this chart is the fact that acidosis by means of acid-forming salts was as effective as fasting in causing decrease in the frequency of seizures".

We believe that NH_4Cl is a good *practical* drug to be added to phenobarbital or other anticonvulsant drugs in the treatment of epilepsy. We cannot state as yet whether its apparent beneficial effects are due to dehydration, acidosis, and change in ionized calcium, or some other factors.

We have used this drug clinically as an adjuvant in a number of cases, over a long period of time. We should be interested in references to similar work done previously.

Sincerely yours,
/s/ Fritz Kant, M. D.
/s/ W. E. Gilson, M. D.

A WORD OF EXPLANATION

Last November a communication was received by all Wisconsin physicians from the Wisconsin Council of the Blind, which seemingly created the impression that the author was going to suggest to the Wisconsin legislature that a bill be passed which would make it a requirement of all physicians to report blindness in their patients to some designated state agency. The wording of the letter caused several physicians to write the State Medical Society, and in order to clarify the intent of the original communication from the Wisconsin Council of the Blind the following statement has been prepared by the original author:

January 5, 1952

Dear Doctor:

On November 26th, 1951, you were sent a letter, signed by me as Executive Secretary of the Wisconsin Council of the Blind. This letter called your attention to the fact that there is an average lag of seven years between the onset of blindness and the discovery of the victim by the agencies which can be of help. Of the twenty-six replies received to date, three have been critical. The office of the Wisconsin Medical Society, (with which we try to work closely) has called and advised that it has also received three critical letters, one of which is yours. I have been asked to write you again and try to clarify certain points. The fact that I have only your name, and have not seen your letter, presents some difficulty, but I will do the best I can.

My father was a physician and I called on physicians for many years as a pharmaceutical salesman, prior to the loss of my sight. In the 1920's, I knew close to five hundred Wisconsin doctors personally. I think I understand the point of view of the busy practitioner. I also know what it means to become blind and not to know where to turn for

The institution is located on Oconomowoc Lake, two miles east of Oconomowoc and 28 miles west of Milwaukee on U.S. Highway 16.

There are 25 acres of landscaped grounds and all the buildings for patients are fireproof.

Senile — *Convalescent* — *Nervous*

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Oconomowoc, Wis.

For further information write or phone
G. R. Love, M. D.
Physician in Charge
Oconomowoc, Wis.

help. In my own case, I was discovered after only two years—by pure accident. One of my doctor friends in a little town in the northern part of the state heard of my accident from another drug salesman. He took it on himself to get in touch with a field worker of the state Office of Vocational Rehabilitation. This man went a hundred miles out of his way to search me out and to tell me of the re-training program that was available to me. I am now an attorney and a very successful business man here in Madison, but I might still be a hopeless victim of misery and despair had it not been for this fortunate circumstance.

Such things should not be left to chance. I had never known any blind people during my sighted life. The only picture I had in my mind was that of a miserable creature on a Chicago street corner, with an accordion and a tin cup. My instinct was to crawl into a hole and pull it after me. I shrank from contact with any strangers and it would never have occurred to me to ask my attending physician to report my case to the state. Had he suggested such a thing, I probably would have objected. My case is wholly typical.

Where financial assistance is an absolute necessity, there is no problem. These people come to the knowledge of the state agency almost immediately. The desperately serious problem is where the victim, through dependence on family or friends, can get along, somehow, without asking for public assistance—without applying for a pension.

Let me make it abundantly clear that we have no wish to force unwanted services on anyone. What we do want is to see to it that every victim of blindness is *made aware* of what these services are, so that he can make an intelligent and informed decision.

There are now approximately three thousand blind or visually handicapped persons in Wisconsin whose identity is known to the Department of Public Welfare. Intensive investigations in many selected areas show that there are at least another thousand who are *not* known.

The local physician is the only one who is in a position to know the situation of these people. It is unlikely that any one physician has so many blind in his immediate area that it would impose an undue burden for him to make careful inquiry and to learn whether or not the individual blind person is in touch with the state agency. The fact that such systematic investigations are not now being made is, we believe, almost never due to any indifference on the part of the doctor, but rather to a lack of awareness, on his part, of the many wonderful things that can be done for a blind person to help him adjust and re-orient his life.

Late in 1950 we sent out a letter to all Wisconsin doctors which was somewhat similar to the one you received a couple of months ago. It was extremely tactful and diplomatic. It caused no resentment whatever and it achieved no results—or almost none. Last winter I interviewed Dr. Neupert and

JUNE 30, 1952

LAST DAY FOR USE OF ANY BUT APPROVED DIATHERMY EQUIPMENT—BUILT IN ACCORDANCE WITH F.C.C. SPECIFICATIONS . . .

(SEE A.M.A. JOURNAL, JUNE 2, 1951, PG. 481)

Let us help you meet the F.C.C. deadline. The Pengelly X-Ray Company, the Northwest's oldest and largest medical equipment dealer is ready to serve you. Our experienced staff and sales organization can help you meet this government regulation before the June 30th deadline. One of our representatives will be glad to call at your convenience. Discuss your particular problem with him. Have him show you the F.C.C. approved Burdick, the world's finest diathermy instrument, your best answer to the June 30th deadline.

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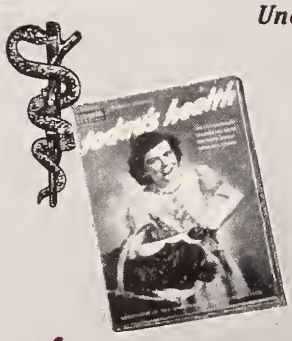

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explained the situation to him. He arranged for me to appear before the Public Policy Committee of your state medical association. I received a most sympathetic hearing. At that time we discussed various types of reporting laws and it was suggested to me that we wait a year or two and see what could be accomplished through purely voluntary co-operation. The Committee also discussed sending out a bulletin of its own.

I am now informed that the state headquarters of your organization is considering making up a little leaflet, describing in some detail the various types of services which are available. We shall discuss, also, at a meeting to be held on January 27th, the feasibility of providing forms on which reports may be made to the Board of Health. We are ready to pay a part or all of the costs involved.

I am very sorry that a few of the recipients of our letter of November 26th, interpreted our reference to a mandatory reporting law as being in the nature of a threat. No such meaning was intended. It is true that such a law was enacted in Massachusetts last year but we are skeptical as to its effectiveness and we do not like such laws, on principle, any better than you do. We would ask our Wisconsin legislature for such a law only as a last resort.

Respectfully yours,
/s/ GEORGE CARD
Executive Secretary
Wisconsin Council of the Blind
605 S. Few St.
Madison 3, Wis.

It is anticipated that through the cooperative efforts of the Committee on Visual Defects, the Wisconsin Council of the Blind, and appropriate state agencies physicians will be provided with information which will assist them in proper referral of all patients with impaired eyesight.

The State of Wisconsin
State Department of Public Welfare
December 7, 1951

Managing Editor
Wisconsin Medical Journal
704 East Gorham Street
Madison 3, Wisconsin

Dear Mr. Crownhart:

I noted with interest your November issue of the Wisconsin Medical Journal in which you published the article "How a Physician Can Help an Unmarried Mother". I am most appreciative of your efforts in assisting us in bringing to the attention of physicians the large part they play in making it possible for unmarried mothers to receive adequate care and service. It is indeed through such cooperation that we are ever hopeful of being able to give better total care to unmarried mothers.

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WANTED: By Wisconsin physician, an associate in general practice. City of 30,000 with hospital facilities. No investment, but special training desirable. Address replies to No. 404 in care of the Journal.

FOR SALE: Office equipment, medical library and instruments of deceased physician. All in excellent condition. Write Mrs. E. Panetti, Hustisford, Wisconsin.

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DESIRES LOCATION: General surgeon, 34, board eligible, married, desires association with group, clinic, or partnership basis. Address replies to No. 415 in care of the Journal.

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FOR SALE: General Electric portable shockproof x-ray unit, $100; slightly used Krazno–Ivy Flicker Photometer for detection of early cardiovascular disease, $165; several Jones basal metabolism units, factory re-conditioned and guaranteed to be accurate and in good mechanical condition, $125. Address replies to C. C. Remington, 1204 W. Walnut St., Milwaukee 5, Wis. Phones, Locust 2–8118 and Woodruff 2–4028.

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FOR SALE: By widow of deceased physician; medical library of 200 volumes, stock of drugs, 3 examining tables with pads, Birtcher Crystal Bandmaster, and a number of other items. Address replies to No. 407 in care of the Journal.

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2. Heller, E. M.: The Treatment of Essential Hypertension. *Canad. Med. Assn. Jour.*, 61:293-299, Sept., 1949.

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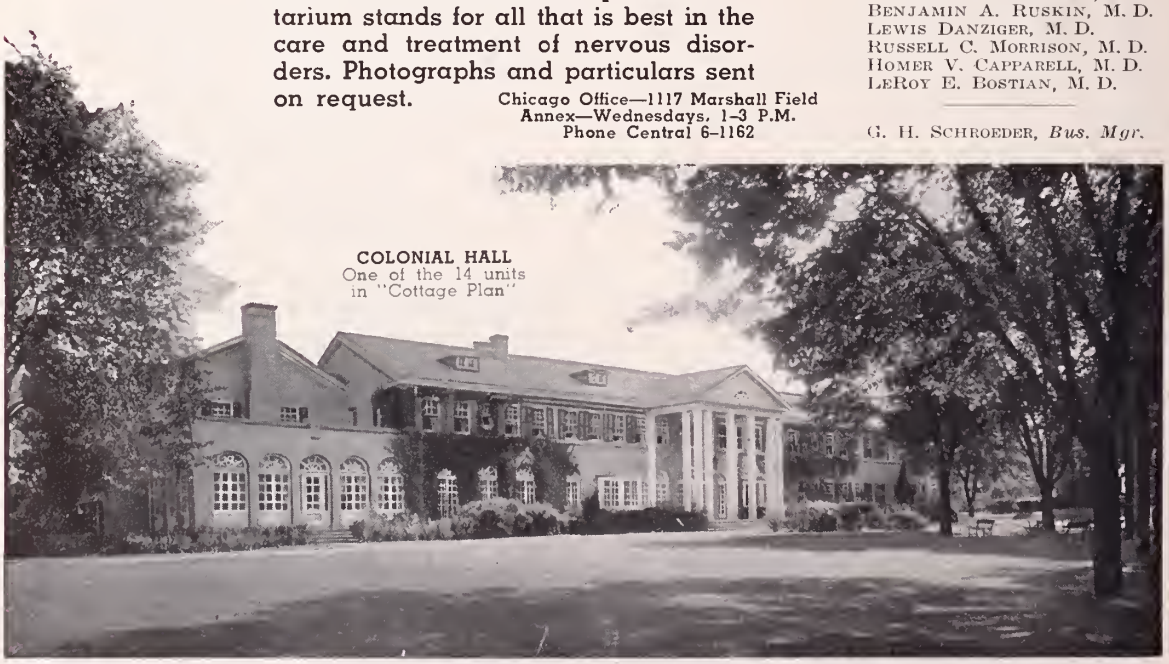

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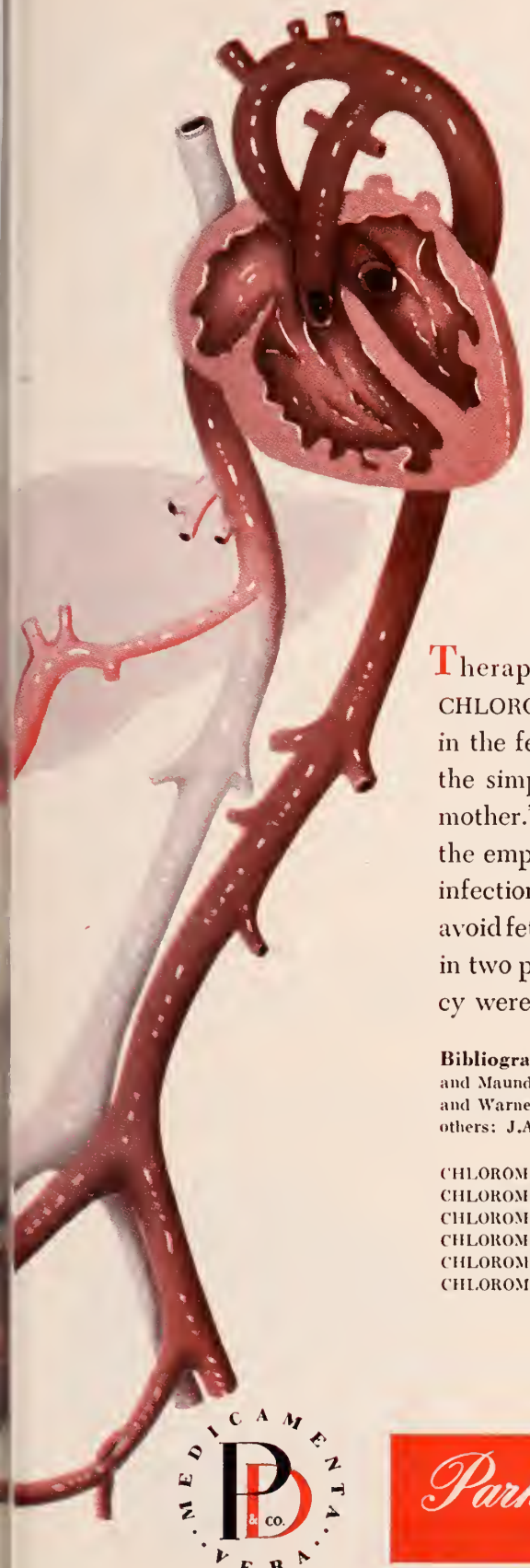

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Bibliography: (1) Stevenson, C. S.; Glazko, A. J.; Gillespie, E. C., and Maunder, J. B.: J.A.M.A. *146*:1190 (July 28) 1951. (2) Scott, W. C., and Warner, R. F.: J.A.M.A. *142*:1331 (April 29) 1950. (3) Ross, S., and others: J.A.M.A. *142*:1331 (April 29) 1950.

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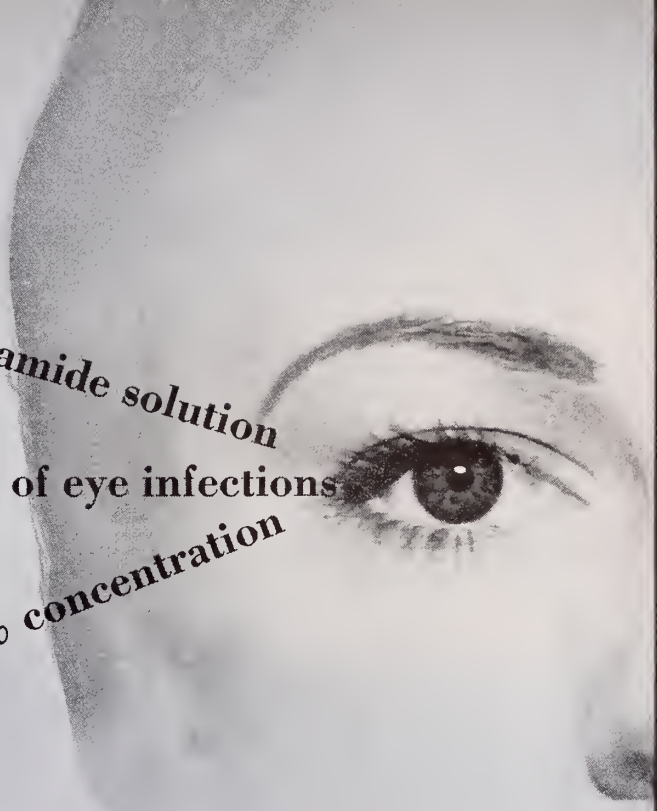

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Ward, L. E., Slocumb, C. H., Polley, H. F., Lowman, E. W., and Hench, P. S.: *Proc. Staff Mtgs., Mayo Clinic* 26: 361, September 26, 1951.

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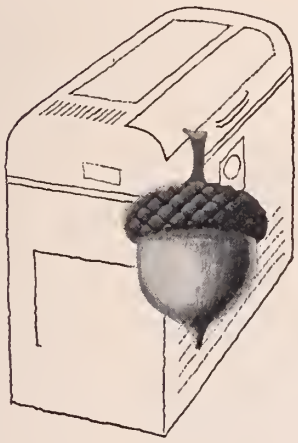

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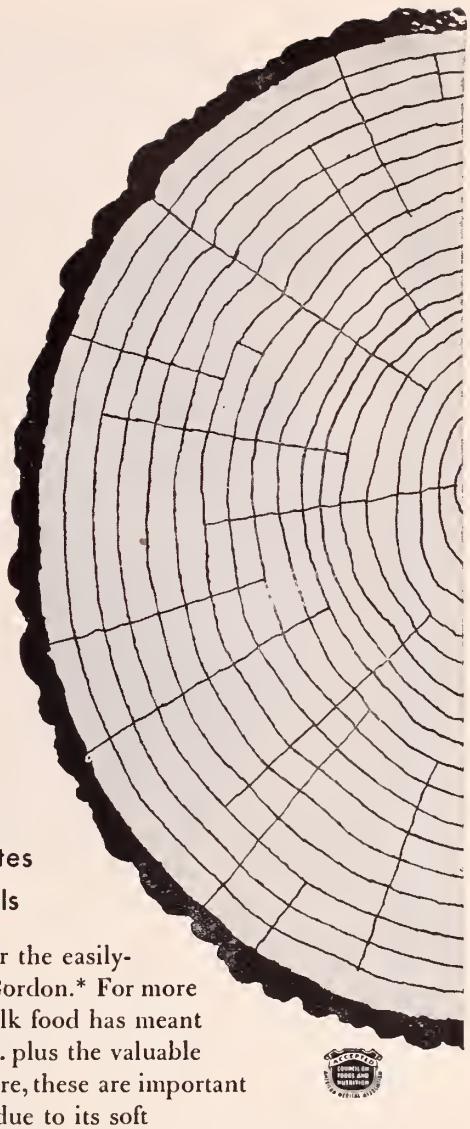

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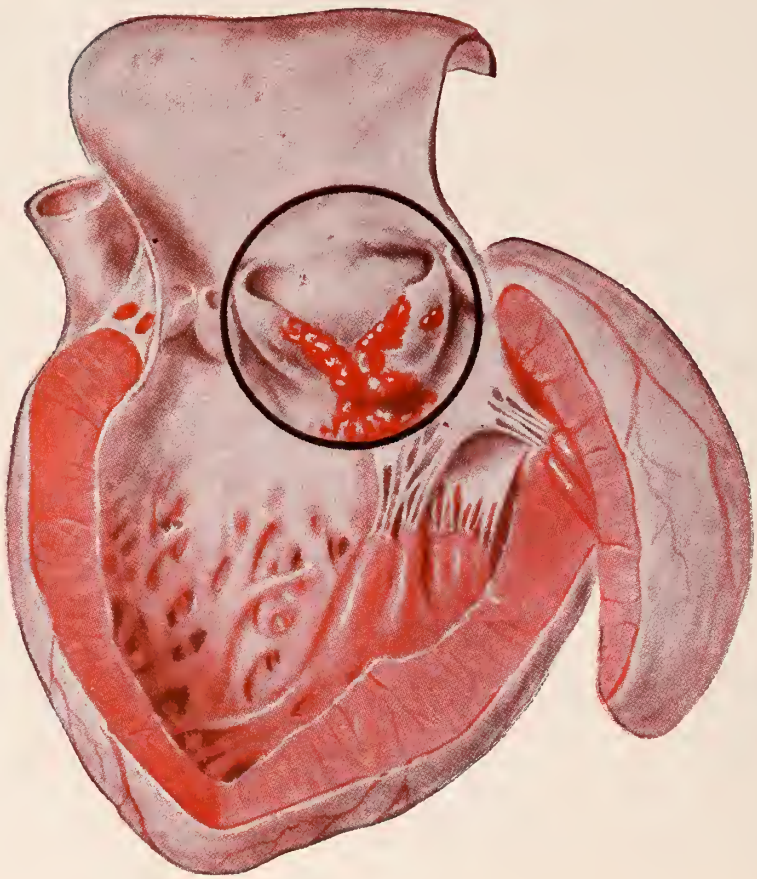

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Blake, F. G.; Friou, G. J., and Wagner, R.R.: Yale J. Biol. and Med. 22:495 (July) 1950.

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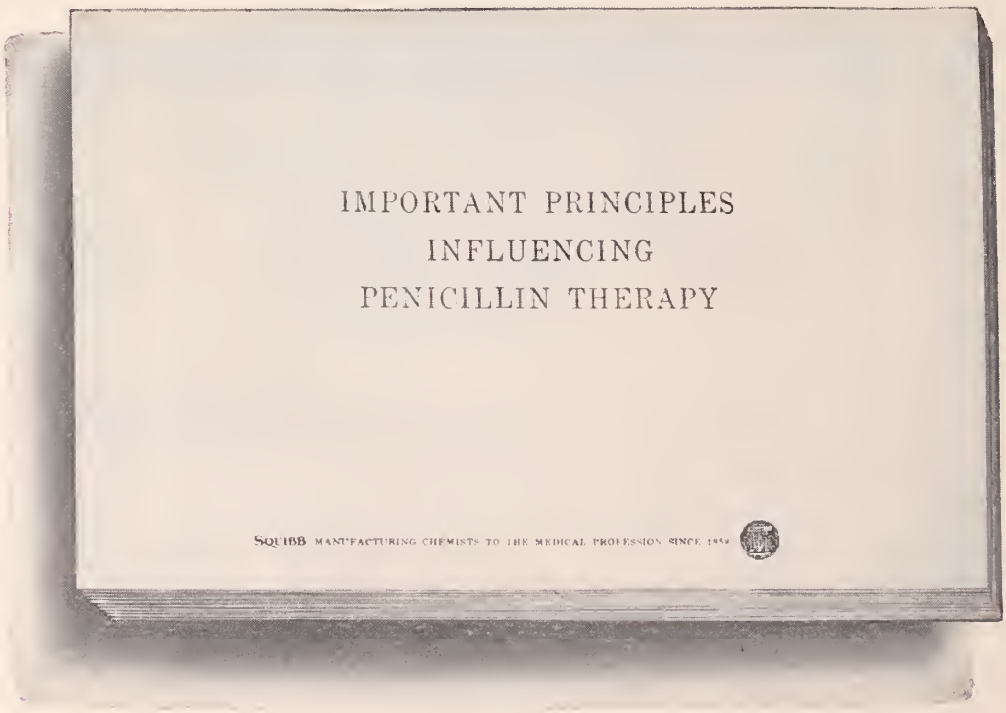

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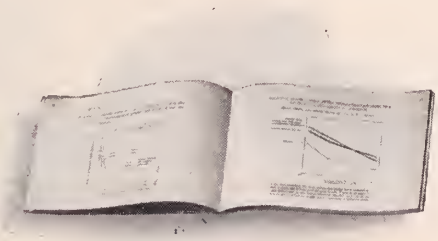

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1. Perloff, Wm. H., (1951) Treatment of the Menopause. II. Amer. J. Obst. & Gynec., 61:670, March. 2. Reich, W. J., et al. (1951), A Recent Advance in Estrogenic Therapy. I. American J. Obst. & Gynec., 62:427, August.

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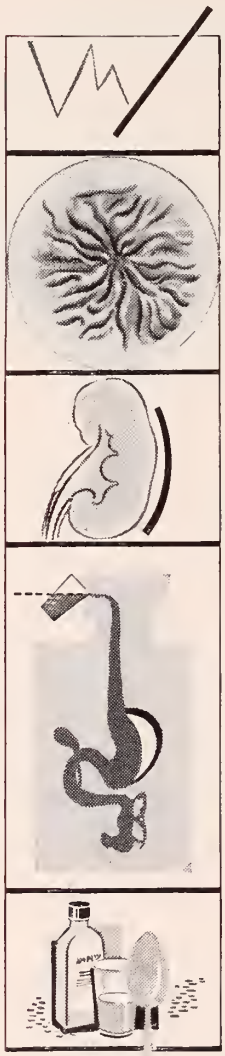

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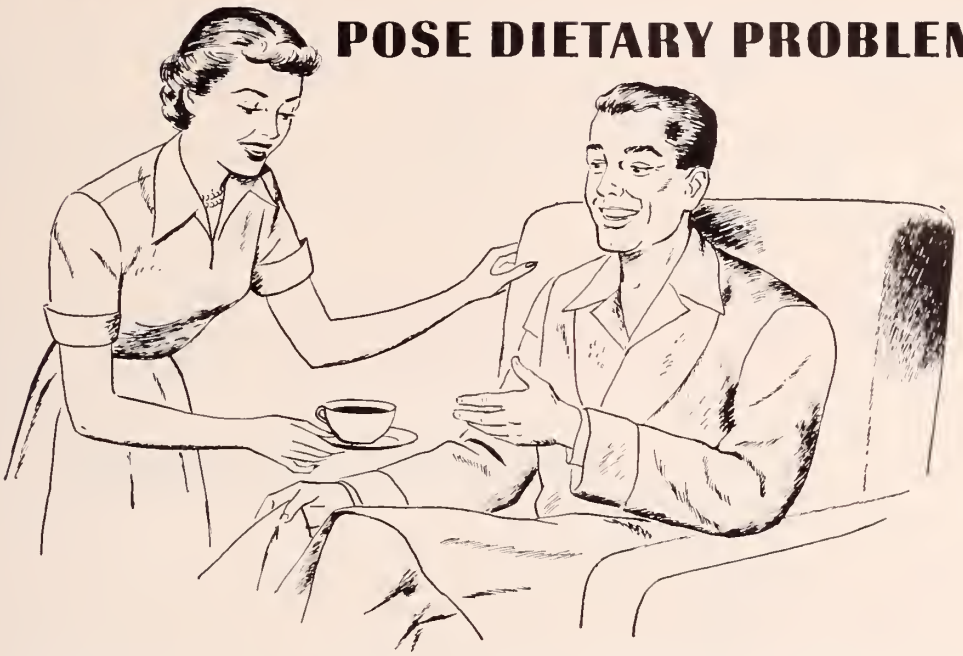

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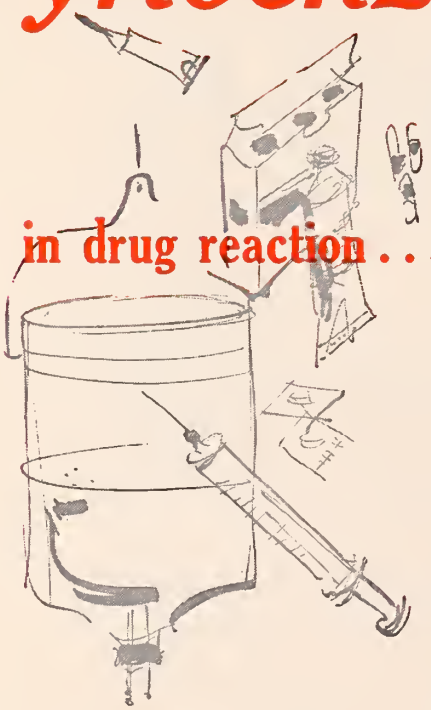

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« « « EDITORIALS » » »

It Could Happen Here

In the February issue of the *J.M.A. of Alabama* an interesting situation is described in Georgia. Mr. R. P. Swan, welfare chairman of Peach County, Georgia, has resigned because his county has more children on relief than in school and because more persons are drawing assistance checks than are operating farms.

Mr. Swan states that many of these children have been abandoned by one or more parents simply because the parents know that the welfare department will provide funds for rearing these children, leaving the parents free to earn, spend, and dump their responsibilities on the government. A particular gripe of Mr. Swan's was that the local board had no authority and that the state and federal control was interested only in spending money and not taking direction or suggestion from the local board.

The whole situation, however, shows what can happen in moral degeneration when more and more security is given a person by his over-zealous government. It further seems that whatever is wrong has not been helped by long distance control of a fund set up to help a bad situation and that this is an example of that historic occurrence which is one of the prime objections to a paternalistic, overcentralized government.

New Prescription Regulations

This month—April 26—the refilling of prescriptions for "Rx Legend" drugs without specific authorization of the prescribing physician becomes a violation of the Federal Food, Drug, and Cosmetic Act as amended by Public Law 215. All physicians are urged to become acquainted with this new law which, in effect, places greater responsibility on the prescribing physician.

Details of the law were printed in the November 1951 Medical Forum of the *Wisconsin Medical Journal* on pages 1107 and 1108.

Starting April 26, all "Rx Legend" drugs, including such drugs as penicillin, barbiturates, benzedrine, sulfa drugs, thyroid and sex hormones, will be labeled by the manufacturer with the legend: "Caution: Federal law prohibits dispensing without prescription."

Prescriptions and refills for "Rx Legend" drugs may legally be telephoned by the physician to the pharmacist, but the pharmacist must promptly reduce the prescription to writing and file it.

Physicians should note that no changes have been made in the handling of narcotic prescriptions covered by the Harrison act. Thus, telephone prescriptions for narcotics and refilling of such prescriptions are not permitted.

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Comments from the Wisconsin Press

Socialized Medicine Far from Dead

"In recent months it has often been said that the socialized medicine movement in this country has been stopped. That idea is largely based on the fact that congress has given the administration-sponsored government compulsory health insurance bill the complete deepfreeze treatment. It would be a grave danger, however, if we came to believe that this is the end of the matter and that there's nothing more to worry about so far as socialized or politically-dominated medicine is concerned. It is probably true that the socialists have given up hope of achieving their goal at one fell swoop, as was done in England. But they undoubtedly plan making progress through a subtle, little-step-by-step technique."—WAUKESHA FREEMAN, March 7, 1952.

* * *

The "Flu" Bug

"Today's bright sunshine was encouraging after a spell of clouds and rain. Perhaps the change will be helpful in reducing what lately has become quite an extensive record of cases of influenza in this area. Many of the instances have been severe, with fever calling for the attention of local physicians and the patients being required to go to bed and remain home until it was safe to resume the 'daily grind.' The new drugs have helped, of course, to reduce the effects of the 'flu' and control the situation. Druggists say they have filled more prescriptions so far this month than in years in the same period.—OSHKOSH NORTHWESTERN, March 11, 1952.

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"Political Plans"

"Plans of the A.M.A. to enter 1952 politics drew comment recently from the Committee for the Nation's Health which advocates national health insurance.

"'The leaders of organized medicine were against 24 out of 34 health proposals introduced in the 82nd Congress,' the Committee said.

"'A.M.A. leaders are having a hard time getting the cooperation of large numbers of doctors, but nevertheless the present leaders of organized medicine are going right ahead to line up the right-wing conservatives of the nation.'"—MIDLAND COOPERATOR, February 11, 1952.

* * *

Rural Health Problems

"There was no report from Wisconsin at the National Conference on Rural Health that was held in Denver. Wisconsin was represented by only five professional workers in the health field, including two country doctors. Among the farm organization representatives and rural people there from the middle west we found none from Wisconsin.

"While the conference heard about many outstanding and successful rural health activities in many states—pioneering programs, progress in bringing medical and hospital care to rural areas, and the like—there was no mention of such achievements in Wisconsin.

"Nevertheless, rural health problems have been getting increased attention in our state in recent years. A few county health councils have been set up—about 11 altogether. The state medical society has sponsored two state conferences on rural health and has been trying to help in placement of doctors in rural communities.—MILWAUKEE JOURNAL, March 5, 1952.

* * *

Medical Care in Rural Communities

"Good modern medical and hospital care is being made available to more Wisconsin rural communities than ever before. Things are definitely beginning to look up in that respect. At least, that is the opinion of some of the state's leaders in the health field.

". . . Every little rural community cannot expect to have a hospital, or even a clinic of several doctors . . . That means then that such new facilities ought to be carefully planned and be assured of adequate public support in the rural areas they will serve. A legislative council committee is 'looking into the matter' of an over-all program, but so far has not done much. Local health committees could be most helpful, but few are very active.—MILWAUKEE JOURNAL, February 14, 1952.

* * *

Health Councils Gaining in Wisconsin

"The health council idea is catching fire in Wisconsin, says the *Wisconsin Medical Journal*.

"It is true that the blaze has begun to burn here and there in the state. . . . The idea may be 'catching fire' in Wisconsin. But in a majority of the counties, it is still waiting for someone to gather the kindling and strike the match. . . . Editor's Note: The above article appeared in a recent issue of the Milwaukee Journal. It provides a general explanation of the purposes of a community health council, which the lay advisory committee to the public health nurse intends to organize in this county sometime in late April or early May. It has been pointed out that Dunn County is one of the few in this area where no such council exists."—MENOMONIE DUNN CO. NEWS, March 12, 1952.

The Penalty of Compulsory Retirement*

By ROBERT E. FITZGERALD, M. D.
Milwaukee

IT IS my pleasure to welcome you to the twenty-fifth annual meeting of the National Conference on Medical Service. As you know, the general purpose of these meetings is to afford an opportunity for free and open discussion of the problems which concern the house of medicine. Many of these are outside the strictly scientific field but are of vast importance to us if we are to attain our goals in the care and treatment of the sick. A perusal of today's program indicates the point I am trying to make: that this organization usually approaches controversial problems for a very definite reason; namely, in order that we may live up to the ideals of the National Conference on Medical Service.

The subject of the care of the aged is one of increasing discussion and interest today due to the growing number of older persons in the United States. In the past 50 years the life span of the average man has increased almost 25 per cent. One of the reasons for this is the improvement in medical education which has given us better trained doctors. Moreover, our armamentarium has increased in all fields. We have improved technics in surgery and medicine, and our research has resulted in the discovery and successful use of antibiotics to an extent where it is easy to understand why, in our nation's population, the older people are increasing faster than any other age group above 10 years of age. Little wonder then that we find a marked increase in interest in the field of geriatrics. It is not my purpose to discuss the common diseases of the aged, such as diabetes, arteriosclerosis, cardiovascular-renal disturbances, loss of sight and hearing, cerebral vascular accidents, and all the other ills which may be concomitants of advanced age, but rather to suggest that we point our thoughts towards those among the aged who are wholly or partially able to carry on their ordinary employment.

Longevity, which is a physical trend, has its parallel in the social-economic field where the trend is toward forced retirement of workers at a given age. While our social security legislation does not state a definite age, it has been demonstrated that with the coming of social security private and public business has more and more come to specify a compulsory retirement age. At the same time persons who have reached the age of 45 have found it most difficult to obtain employment, a situation which has its origin in the thought trends which accompany our expanding social security legislation as well as in the reluctance of many businesses to admit to employment those whose years of productive work have become relatively few under established pension plans. During World War II there were many men and women who left jobs where they had established seniority in order to aid their country in its defense production. With the cessation of the fighting many of these jobs became non-existent and many more were filled by the returned soldier who had prior claim. As a result, society found itself with a sizable number of people in the 40 or 45, or even 50, year groups who were without employment but who were willing and able to work. Motivated by patriotism and, if we are to be realistic, by the high wages paid in defense industries, these people left the jobs they had held and were now left by their jobs.

America has made a cult of youth, and employers are reluctant to engage any but young men. In most businesses we find modern personnel methods have adopted a career policy of promotion from within. There is little or no interest in hiring men who have reached their middle forties. And yet what are these people to do? They are willing and able to work but the passing of each day makes them less likely to be engaged by a new employer. Employers contend that workmen's compensation rates go up with the employment of the elderly, that older workers have more accidents and endanger other workers, that the public prefers younger workers in jobs requiring public contact, that the rate of production of the elderly employee is noticeably lower, and that, generally, it is expensive and unprofitable to train older workers. Exhaustive and authoritative studies conducted by a New York state committee on the problems of the aging resulted in a statement by the committee that the aforementioned reasons are denied by many authorities and that, all in all, many of these notions that militate against the hiring of older workers have no basis in fact, that others are based on greatly exaggerated situations, and that a progressive change in personnel methods could combat all the common objections to employing the older man.

The policy of compulsory retirement which obtains in most public and private business today has developed to a great extent from the contention that man has earned the right to cease his labor at a certain age, and that his withdrawal from productive employment is a good thing. Yet how many of our more than 25,000,000 Americans who are between the ages of 45 and 65 are prepared for the leisure which is forced on them by existing retirement schedules? The answer to this question denies the original contention. Compulsory retirement takes out of gainful employment vast numbers of men

*The presidential address given at the National Conference on Medical Service, Chicago, February 11.

and women still physically and mentally able to continue in their occupations. There are many facets to this problem and not the least important is the economic one. Despite pensions from employers and the receipt of social security remittances, many exworkers find their incomes materially smaller and their standard of living correspondingly lower. This has come about through no disability of their own but because arbitrary rules have designated them as unemployable. Those who have succeeded in saving enough money to augment the income that is theirs through social security payments or old age pensions form a pitifully small minority in this day of increased taxation and spiraling living costs. A contributing factor to this situation is, I will admit, the lack of esteem for thrift that is evidenced not only by the American working man and his family but more alarmingly and to a much greater degree by his government.

Along with the economic consideration comes the social one of what to do with the leisure time that a retired employee now has in superabundance. If a program of education in ways to spend these added, and sometimes endless, hours had been instituted several years before the incidence of enforced retirement, our picture might be a brighter one; although even then it takes an active imagination to conjure up a picture of a vigorous and ambitious executive or worker exchanging, with any great degree of satisfaction, his old duties for something in the hobby class. There are, of course, exceptions where we find good adjustments made, but too often we find the retired man deteriorating mentally and physically because circumstances have convinced him that he is no longer useful. A man who has been happy in his work for many years experiences a feeling of irreparable loss when it is taken away from him.

For many years our conception of old age was of an old man living out the last years of his life doing small tasks on the farm now being worked by his sons, or in a small town where he had served the people for many years and has now curtailed his activities of his own volition. We have had pictures in our mind's eye of old ladies taking care of grandchildren or baking an occasional pie in a roomy kitchen. Always there appears in our nostalgic picture of the old, the family unit occupying its own home with the elders serenely enjoying the fruits of their labors in quiet contentment. There is a haze of sweetness and light over the whole and now completely unrealistic scene. Today the structure of our population has changed from a predominantly rural or semi-rural one to a 64 per cent urban one. The elders are much more apt to live in an apartment with a kitchenette or in a small bungalow than anywhere else. It is improbable in these surroundings that they will have an opportunity to take over the light chores that were traditionally theirs a generation or two ago. Our old people, as well as our young, are feeling the effects of centralization and industrialization. The resiliency of youth accepts this as a part of the whole pattern of development; to the aged, who must face enforced retirement along with this situation, it is apt to become tragic.

What can we do about this problem? We, as custodians of the health of our fellow men, have a definite responsibility to do everything within our power to solve it. Organized medicine has been confronted with criticism from those outside the profession and has shown its good faith by policing its own members through grievance committees. A good job has been done, and as a result our public relations have improved immeasurably. The present problem of our aging population is one which, in a manner of speaking, we have brought upon ourselves, to the degree that the medical profession has done so much toward increasing man's life span to its present high level. Consequently, we should stand willing and ready to help. As Dr. Howard Rusk has said, "We have added years to life; now we must add life to years." It is unthinkable that this responsibility should be passed on to the government, particularly in view of the disagreement over policies in the Veterans Administration and other bureaus. There are some suggestions we may make toward alleviating the present condition. First, why not return to the policy followed during the war when all available manpower was put to use? This would mean the end of compulsory retirement; and at this time of full employment and increased military demands on manpower, it would also mean a thrifty use of the already trained worker without endangering the advancement of the younger man in industry.

It would not mean that all of the elderly would be kept in employment but only those who are still completely able, both physically and mentally, to perform their regular work. It is a deplorable waste to allow calendar years and not ability to dictate the termination of a man's active participation in his work.

History has given us many examples of people who have done some of their greatest work at an age far beyond that at which they would be retired by most businesses today. Beethoven, Goethe, and George Bernard Shaw made some of their greatest contributions to our culture when they were many years older than 65. It is true they were geniuses and their works masterpieces, but is it not conceivable that a vigorous and alert John Smith could do his ordinary work as well at 70 as at 50?

One of Belgium's outstanding lacemakers today is 85 year old Mrs. Sabine Lucas. At 81, Captain Mary Green is one of the hardiest steam boat pilots in our country. New York boasts of an 81 year old taxi driver, George Pierson, and there are many others. Recently we have had a visit from a great English statesman in his late 70's; not even the British Socialists could retire Winston Churchill. And what of our own Herbert Hoover, Bernard Baruch, and Douglas MacArthur who at 72 is at the height of his physical and mental powers?

Another suggestion I would make is that there be planned programs for part-time employment in industry of those who are over age and, while not incapacitated, are not now able to carry the full burden of their previous jobs.

It would seem that community planning for the establishment of employment agencies for those elderly folk who wish to undertake light work within their curtailed physical capacity would be desirable. Too, it would be helpful to promote educational programs which would encourage retired folk to cultivate hobbies which would not only add to their zest for life but might, as in certain types of handicraft, add to their incomes.

Doubtless there are many other suggestions which may come to your minds. We must admit that to expect a completely ideal answer to the question of how to make life happy and full for the vastly increased number of aged in our country is utopian; but with sound policy and concerted action we can look toward great improvement in the status of the physically and mentally sound men and women who have been forced into retirement from a life of usefulness to one which may seem devoid of everything that makes living worth-while. I hope the time will come when we will no longer penalize a man for his birthdays and disregard his ability.

2218 North Third Street.

SCHEDULE OF PROGRAMS OF THE "MARCH OF MEDICINE"

On April 1, 1952, the March of Medicine began its seventh consecutive year of radio broadcasting. The programs, which are tape recorded, feature Dr. R. C. Parkin discussing various health problems with a lay person who is called "Your Medical Reporter." At present 33 stations in Wisconsin, one in Michigan, and one in Minnesota are cooperating in presenting this program as a public service feature. The most recent schedule is as follows:

Station	*City*	*Time*	
WHBY	Appleton	Saturday	8:30 a.m.
WBEV	Beaver Dam	Saturday	9:30 a.m.
WHKW	Chilton	Saturday	10:30 a.m.
WHWC	Colfax	Saturday	10:30 a.m.
WHAD	Delafield	Saturday	10:30 a.m.
WEAU	Eau Claire	Saturday	1:30 p.m.
KFIZ	Fond du Lac	Saturday	8:15 a.m.
WBAY	Green Bay	Saturday	9:00 a.m.
WHLA	Holmen	Saturday	10:30 a.m.
WJMS	Ironwood, Michigan	Saturday	8:15 a.m.
WCLO	Janesville	Saturday	6:35 p.m.
WLIP	Kenosha	Saturday	11:15 a.m.
WKBH	La Crosse	Saturday	11:00 a.m.
WLDY	Ladysmith	Saturday	10:15 a.m.
WHA	Madison	Saturday	10:30 a.m.
WIBA	Madison	Saturday	9:00 a.m.
WOMT	Manitowoc	Saturday	10:15 a.m.
WMAM	Marinette	Saturday	2:30 p.m.
WDLB	Marshfield	Saturday	8:45 a.m.
WIGM	Medford	Saturday	11:30 a.m.
WEMP	Milwaukee	Sunday	1:00 p.m.
WEKZ	Monroe	Friday	2:00 p.m.
WNAM	Neenah	Wednesday	10:45 a.m.
WOSH	Oshkosh	Saturday	9:45 a.m.
WIBU	Poynette	Thursday	2:30 p.m.
KAAA	Red Wing, Minnesota	Monday	9:15 a.m.
WOBT	Rhinelander	Saturday	8:30 a.m.
WHRM	Rib Mountain	Saturday	10:30 a.m.
WJMC	Rice Lake	Saturday	10:30 a.m.
WRCO	Richland Center	Wednesday	10:00 a.m.
WHBL	Sheboygan	Sunday	1:00 p.m.
WLBL	Stevens Point	Saturday	10:30 a.m.
WDOR	Sturgeon Bay	Thursday	9:15 a.m.
WDSM	Superior	Sunday	10:00 a.m.
WSAU	Wausau	Monday	4:45 p.m.

Recognition and Treatment of Vaginal Diseases*

By H. CLOSE HESSELTINE, M. D.**
Chicago, Illinois

DISEASES of the vagina include congenital anomalies, infections, neoplasms, allergies, and abnormalities due to physical agents such as chemical and thermal burns, irradiation, and foreign bodies. I propose to consider mainly the more frequently encountered diseases but will also include a few of the less common conditions which can be of serious import to the patient, especially those whose prompt recognition and proper treatment can prevent serious disability.

Usually, vaginal diseases make themselves evident to the patient by discharge, vulvar pruritus, bleeding, the appearance of a mass in the introitus, dyspareunia, and, occasionally, pelvic discomfort. Vaginal diseases as a rule do not cause symptoms in the rectum or bladder. Vaginal symptoms are absent often because of the lack of supply of sensory nerves as compared to the skin, vulva, or mouth. Hence vulvar symptoms may be due to vulvar lesions or disease of higher level. Table 1 lists some of the conditions which deserve consideration. Some are included for differential diagnosis as well as direct diagnostic import. As never before diagnosis is so important, for therapy depends upon the diagnosis. Our present-day therapies have advanced so

TABLE I.—*Some Vaginal Diseases*

Infectious	Non-Infectious
1. Venereal Diseases Syphilis Chancroid Granuloma inguinale Lymphogranuloma venereum	1. Chemical burns and sensitization
2. Mycosis	2. Irradiation
3. Trichomoniasis	3. Mechanical Foreign bodies, etc.
4. Postmenopausal vaginit's	4. Neoplasms, benignant Cysts Endometriosis Miscellaneous
5. Childhood vaginitis	5. Neoplasms, malignant Primary and secondary
6. Tuberculosis	6. Excessive cervical secretion
7. Rare	

far that a number of conditions are treated by specific therapies. In general, diseases of syphilis, chancroid, granuloma inguinale, and lymphogranuloma venereum may manifest themselves in the vagina or upon the cervix as well as upon the vulva. Frequently the primary lesion and even the secondary lesions of syphilis are unrecognized in the vagina since they may be symptom free. More often they are found by chance because of more thorough examination of the patient. Chancroid, granuloma inguinale, and lymphogranuloma venereum tend to have the same characteristic appearance in the vagina as upon the vulva. The diagnostic methods are well established for these conditions, and their treatment is equally specific and standardized.

Since venereal diseases fall into a special category, they will be eliminated from this discussion except for some manifestations of the gonococci. Gonococcal infections in the vagina of the adult woman are unimportant since they do not occur with any frequency or last for any particular period of time. This infection is very important in the primary sites of the urethra and cervix. Vulvovaginitis in the child is very important since it persists unless treated. It is also a real menace for it spreads easily in pediatric services and even in grade school. This infection is readily controlled by penicillin and also by proper amounts of estrogen.

Tuberculosis of the vagina is seldom encountered in private patients. It will be found more often in the hygienically poor and in groups more susceptible to tuberculosis. It reveals itself by an ulcer-like lesion. The ulcer is usually firm, with an irregular edge, which is commonly undermined. It is characteristically tender and painful. When this lesion is found in the vagina, one must suspect the possibility of a primary lesion in the patient's chest, or gastrointestinal or genitourinary tracts. Occasionally such a lesion will be found in the vagina when there is tuberculosis of the endometrium. The lesion may be found in women without evidence of tuberculosis elsewhere, and in this event the husband must be considered as the source. His pulmonary or genitourinary systems come into first consideration. The diagnosis of the ulcer is confirmed by smear or biopsy. Treatment consists of regular management of the primary site. A single lesion of the vagina may be excised. Dihydrostreptomycin may be of value in clearing the local lesion.

Acute vaginitis may be encountered without a definite history from the patient at first. However, as confidence is established or the history is unfolded, it may be revealed that an improper amount of medication has been used. Yet an occasional patient is sensitized to certain agents. One must be open minded to the possibility of a sensitization or a chemical burn. Today these are more likely due to picric acid or gentian violet. After the initial reaction to the medicament there is a likelihood of a secondary infection with all of the complications of both states and the pain and distress to the patient. For this reason alone caution and judgment must be exercised in the advocacy of vaginal therapy either as a treatment or in douche form.

Irradiation, either x-ray or radium, may cause a necrosis or other reaction with the corresponding

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** From the department of obstetrics and gynecology of the University of Chicago, and the Chicago Lying-in Hospital.

type of process. Likewise, a break of the mucosa from trauma or insult may be the portal of an infection. Cicatricial contracture or firm adhesions result when major damage occurs, with the submucosal tissue so severely injured the elastic tissue structure vanishes. Neglected or forgotten foreign bodies, as pessaries, may penetrate a considerable distance. Pelvic abscesses can result from such apparatus that are not periodically removed and cleaned, and the vagina inspected for pressure necrosis. When necrosis is imminent or likely, then the pessary must be left out until healing has occurred. Then a new fitting may avoid the recurrence. Objects, such as a tampon, contraceptive equipment, sponge, or a cotton ball, may be the source of irritation and discharge. Mentally ill patients are more likely to place foreign objects in their vagina. Infant and small girls may have foreign bodies in the vagina. The principal symptom is vulvovaginal discharge. The foreign bodies may be diagnosed by vaginoscopic examination (using a small electrically lighted urethroscope). X-ray pictures of the pelvis may give evidence of the foreign body if it is radiopaque.

Benign neoplasms such as cysts of the wall, regardless of whether they are müllerian or wolffian ducts in origin, as well as inclusion cysts from laceration, episiotomy, or operative repair, should be treated as a simple benign lesion and removed or evacuated with ample incision whenever there are symptoms or distortion of the vagina.

Primary malignancies of the vagina are extremely rare and secondary lesions only indicate the extensiveness of the process and the poor prognosis likely to be available to the individual.

Excessive secretion of the introitus may also come from the cervix. Again, the primary condition should be treated and not the symptom.

Vaginal mycosis is a frequent complication in pregnancy, usually beginning in the second trimester. The vaginal mycosis may be found in nonpregnant women, but these women are likely to be diabetics or have had excessive estrogenic therapy. This condition is caused by the Candida albicans or a monilia. These conditions are never due to yeasts. Yeasts are entirely of another species and totally unrelated to these pathogens. Yeasts are strictly nonpathogenic. They are used commonly in bakeries, wineries, and breweries. Mycosis of pregnancy will have its invariable symptom of itch. The pruritus may be so severe as to disturb rest. Inspection will reveal either thrush-like patches on the vaginal wall or caseous material in the vagina. A small amount of this material placed in a drop of water on a slide is the most direct way for confirmation. Under low power or high power magnification one will be able to pick out the branched mycelia and the buds or conidia.

A large number of women are carriers of these organisms during the pregnant state and yet do not develop the disease. The organisms are entirely opportunists, and their manifestation is local. Systemic spread is rare and unlikely outside the newborn period. In the nonpregnant state, the carrier rate is 10 to 15 per cent, while in pregnancy the incidence will range from 14 per cent in a private patient clientele to 33 per cent in an economically and hygienically low group, to 41 per cent in a poor, Negro group. Only a limited number of carriers develop the disease. If the condition is untreated, the patient will have considerable disturbance of sleep. The baby is very likely to be exposed to contamination during birth. Since the oral mucosa is particularly susceptible, there is a high rate of oral thrush in babies of mothers with active mycosis. The carrier state mothers do not present nearly such a risk. The material may be introduced into the baby's mouth either during birth or afterward by the obstetrician in cleaning the baby's mouth while he has on his contaminated glove or still later by the mother who carries these organisms to the baby's mouth either by her hands or by the nipples. A logical explanation for this predisposition during pregnancy is the increased glycogen-like material in the vaginal mucosa because ordinary sugars, with the exception of lactose, favor the growth of these organisms and the production of these symptoms. When the organisms are not present, glucose will not produce or cause any of these reactions or changes.

It is a well established fact that the estrogenic response in the vaginal mucosa during postmenopausal therapy or under this influence in pregnancy causes an increased amount of glycogen-like material in the vaginal mucous membranes. The standard treatment for many years was one per cent gentian violet in either aqueous or glycerine vehicle. In the last few years several different agents have been tried clinically after experiments in the laboratory offered promise. Bayard Carter of Duke University had very good results with proprion-jel. A large number of chemicals and agents have had careful scrutiny in my laboratory; yet so often the promising ones failed miserably in clinical trial. It was a surprise to find that ricinoleic acid did have such a profound influence in clinical application to mycosis of the vagina. Three per cent ricinoleic acid with 0.5 per cent oxyquinoline has given a high cure rate. In our first primary report we had 79 per cent cures. The failures were almost always the result of the patient's premature interruption of the therapy, merely because she had symptomatic improvement. If patients will follow the advice exactly and give complete cooperation, the cure rate should be essentially 100 per cent. The material is known as Aci-Jel. It is nontoxic, nonirritating, odorless, and non-offensive. This can not be said of gentian violet. Treatment during pregnancy reduces the risk of oral thrush to the newborn and gives the patient a great deal of improvement. It requires two to four more weeks to effect a cure. Treatment can be carried up to term safely.

The adult human vagina normally has a cell content of essentially epithelial nature. In the presence of inflammation or infection, the epithelial cells be-

come reduced in number, and the cellular content is essentially dominated by leukocytes. Whenever there is an epithelial cell dominance, the bacterial flora will contain acidophilous bacilli. In the normal adult vagina this organism is almost the only one present. These organisms are apparently responsible for the acidity of the vagina, for the vagina is never as sharply acid in their absence. As these acidophilous organisms disappear the bacterial flora changes to that of a mixed group of gram negative and positive organisms very similar to that of the intestinal flora. By cultural means one can find a great variety of organisms (aerobic and anaerobic) in the apparently normal vagina, but this is not evident on direct smear. There has never been established a verified diagnosis of vaginal hyperacidity. Vaginal trichomoniasis has been treated with a number of preparations such as Devegan and Floraquin. The early and mild infection can be cured with any of a number of products that have been recommended. The persistent or chronic ones, however, present other problems. It is not only a matter of eliminating the trichomonad from the vagina, but there is also the problem of finding a focal site. The focal site is usually the cervix or the patient's urethra and bladder. Although there has been no proof to substantiate the claim, it is believed that good anal hygiene is important as a prophylactic step. It has been shown that in the severe trichomoniasis submucosal lesions in the vagina may be present. These take on the nature of an intense local inflammatory process or possibly may terminate in small localized suppurative processes. Thus, chronicity may be explained in another way. Plain lactose, alpha or beta, has been as good as any other agent in our hands.

Beta lactose is dispensed in no. 12 veterinary capsules, while alpha lactose in large pills is available. A douche is permitted once a week to make sure that there is not an excessive accumulation in the vagina. This douche may be plain water or a quart of water to which is added one teaspoonful of powdered alum or two tablespoonsful of table salt. Sodium bicarbonate should not be used for it temporarily affects the pH in the wrong direction. Vinegar and lactic acid, although sound in the idea of favoring an increased vaginal acidity, do not achieve any fundamental change. Hence, acids are rather ineffective.

Whether the trichomonads or the associated bacteria cause the trouble is an academic subject. The clinical entity is distinct. The foamy, bubbly yellowish profuse discharge with a fetid or putrid odor is typical. In severe cases the vagina becomes roughened. Dyspareunia may be a dominant part of the complaints. If the process is chronic or is persistent, the local therapy must be maintained while every potential infected focal site is being treated. It may be necessary to have a careful urethroscopic or cystoscopic examination to make sure about the patient's urinary tract. Any cervical lesion should be treated and cleared. Even excessive cervical secretion itself tends to favor the perpetuation of the disease. Abstinence is insisted upon during the course of treatment. If a recurrence follows coitus, then the husband should be examined. The female child is unlikely to have trichomoniasis.

It does occur in moderate frequency in the postmenopausal patient. The postmenopausal patient can be treated readily and successfully by 0.5 mg. of stilbestrol, daily, taken immediately before retiring for two to three weeks. After this time it may be taken on alternate nights for another two to three weeks and then discontinued. Postmenopausal vaginitis has a bacterial flora similar to that of trichomoniasis. The cellular content is similar also to that of trichomoniasis. The postmenopausal vaginal mucosa is thin and lacks the glycogen-like material. It is evident then that postmenopausal vaginitis occurs readily because of the little protection. The vaginal mucosa responds rapidly and wholly to estrogens.

Conclusions

There are a large number of diseases of the vagina. Anomalies are infrequent. Infections are common; although venereal diseases have been somewhat reduced, they occur far too frequently.

Vaginal mycosis occurs usually in pregnancy, but occasionally in the postmenopausal woman on estrogenic therapy. Three per cent ricinoleic acid with 0.5 per cent of oxyquinoline in a trajacenth-acacia jel has given very satisfactory results. It is produced under the name Aci-Jel. It is nontoxic, nonstaining, nonirritating, and it is economical.

Vaginal trichomoniasis is a persistent infection. It is rapidly cured in the postmenopausal patient by 0.5 mg. of stilbestrol each night for three weeks and then on alternate nights for another three weeks. During the reproductive period plain alpha or beta lactose have given as good results as any other materials available. The course of treatment is long—usually lasting for four or more weeks. If the disease persists, then all focal sites, as the urethra, bladder, and cervix, must be carefully investigated. Any focal inflammatory process must be treated at the same time as the vagina.

Noninfectious processes, as chemical burns and sensitization, must be recognized. Gentian violet and picric acid are the most likely agents today.

Irradiational burn and foreign body injury must be considered where such are possible, the latter especially in small girls and in mentally ill women.

Neoplasms of the vagina need appropriate management.

Some less common vaginal lesions have been listed. This list is extremely brief in number but covers the great percentage on a numerical basis. Careful observation and proper tests guided by good clinical judgment and balanced by proper therapy will give the good results which free enterprise has evolved. The advance of medicine is a preview of the future so long as we can exchange views, discuss problems, study and investigate at the level of personal interests and scientific curiosity, and have appropriate help and support for research.

Treatment of Granulating Burns*

By SIDNEY K. WYNN, M. D.
Milwaukee

BURNED areas not healed by the end of the third or fourth week are usually covered by granulation tissue. These granulating surfaces require special procedures if complications are to be avoided. Further delay of definitive treatment is no longer justified and will only increase the chances for the development of debility, infection, hypertrophic scar formation, contractures, carcinomatous degeneration, and other complications.

Fig. 1.—Granulating surface of ten months duration in a child, age eight years. Note height of soggy granulations.

Figure 1 illustrates what happens when a granulating surface is allowed to go on indefinitely without proper care. The most common error made in the handling of these conditions is procrastinating too long before skin grafting is undertaken.

Not all granulating surfaces require skin grafting. Small areas, less than 5 cm. in diameter, of short duration, can be treated conservatively. Any one of several healing, antiseptic, epithelializing ointments can be used. They should be applied sparingly on a single thickness of fine mesh gauze and covered by coarse mesh dry gauze.

Larger granulating surfaces, more than 5 cm. in diameter, and those which look as though they would need more than three weeks' additional time to heal will require skin grafts.

Preparation of the area for skin grafting is best accomplished by moist dressing and soaks. For soaking small areas on the extremities a Bunyan–Stannard envelope is satisfactory, and for larger surfaces a burn tub with a canvas hoist is of great help. If these are not available, other containers can be improvised.

After soaking, the granulations are covered with a single thickness of fine mesh gauze soaked in warm normal saline solution. Over this is wrapped a five yard roller soaked in warm normal saline solution, and a sheet of oiled silk and a bath towel to keep the bed dry. All wet dressings except the single thickness of fine mesh gauze on the granulations should be changed at least once daily. When the granulations are flat, bright pink or red, with a minimum amount of secretion and infection, and no surface necrotic material, the patient is ready for the application of split-thickness skin grafts.

The type of graft and location of donor site is determined by the location and extent of the granulating surface. The color and texture of the graft should match the area grafted as nearly as possible. Thigh skin, for example, should not be transferred to the cheek because of the difference in color.

The sheet of split-thickness skin should be as large as possible in order to reduce the number of joining scar lines. Pinch grafts result in disfiguring scars, both in the recipient and in the donor sites. With proper instruments and technic, they no longer need be used.

The hand knife is suitable for small areas and thin, split-thickness grafts. Larger areas are best obtained with such instruments as Padgett or Reese modification dermatome, the vacutome, and the electric dermatome.

The following 2 case reports are cited to illustrate a solution to the problem of attaining adequate skin coverage in the shortest time.

CASE 1.—Mr. H., age 31, burned both legs and both hands on December 11, 1949, when the Stanisol he was using to clean the floor of the city garage caught fire. At the time of the first consultation on January 13, 1950, the burns presented the appearance as shown in figure 2.

A granulating wound on the left leg, the result of third degree burns, extended from the lower one-third of the thigh to the ankle and covered the

* Presented, in part, at the One Hundred and Ninth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1950.

Fig. 2.—Mr. H., preoperative.

entire circumference of the leg. The granulations were extremely painful when dressed and bled moderately. A moderate amount of purulent drainage appeared on the fine mesh gauze immediately overlying the granulations. There were spotted areas of epithelialization about the knee and lateral aspect of the leg. The right leg had a small granulating wound as a result of the third degree burn on its medial surface.

Fine mesh gauze in a single thickness was applied to the granulating wounds and changed every 24 hours; above these, massive warm normal saline dressings held in place with five yard rollers, were applied and changed every 3 hours during the day and every 4 hours during the night. With this treatment the patient was ready for skin grafting on January 28, 1950.

Under general anesthesia, six dermatomes of skin were taken, four from the right thigh and two from the abdomen. Two of the dermatomes from the right thigh were taken in sequence so that one of the pieces of skin was 10 by 40 cm.; the other dermatomes were 10 by 20 cm. The donor sites were covered with fine mesh scarlet-red gauze and massive pressure dressings.

As granulation tissue was removed from the entire third degree burn of the left leg, a great deal of hemorrhage from hundreds of points was encountered. This was controlled by application of a tourniquet high on the thigh, and by covering the

Fig. 3.—Mr. H., postoperative.

raw surface with bovine thrombin solution and a warm wet five yard roller of gauze.

With this type of burn it is difficult to tell how much deep tissue necrosis there may be, and since skin grafts directly over granulations do not take well no matter how clean they appear, the safest procedure is to dissect down to healthy, normal tissue before applying grafts.

Following drying of the wound, the six dermatomes of skin were applied. The grafts were sutured together so as to cover the entire raw surface and yet avoid circular bands on the leg which might later give scar tissue circular contracture. After suturing, the under-surfaces of the grafts were irrigated copiously with warm normal saline solution. Fine mesh vaseline gauze was then applied over all grafts and covered by massive pressure dressings. The leg was placed in a splint, and the tourniquet was then removed. The patient was given 1,000 cc. of blood during the surgery to make up for the blood loss and he left the operating room in good condition.

The first day after the operation he was comfortable and no longer suffered the agony he had with the open granulating surfaces.

The initial dressing was done 10 days postoperatively and sutures were removed. The grafts were found to have taken almost 100 per cent. Donor sites were dressed 14 days postoperatively and were completely healed.

Pressure dressings were kept on the leg for another three weeks, after which physiotherapy was begun to hasten softening of the skin grafts and improve the function of the knee. The patient was discharged from the hospital on March 4, 1950, with all areas completely healed except for a small 1 cm. ulceration in the left popliteal space. (See figure 3.) He continued to receive physiotherapy as an outpatient until May 4, 1950, when function had returned 100 per cent and the grafts had softened. He then returned to work completely healed. For six months he wore an Ace bandage on the leg to support circulation while in an erect position.

CASE 2.—Mr. S., age 23, presented a still greater problem. On January 12, 1950, he sustained burns on both legs, hands, and buttocks as the result of ignited gasoline.

Examination of the patient's burns at the time of the first consultation on February 9, 1950 revealed a total of over 3,600 square centimeters of raw granulating surface. Both lower extremities were entirely covered with granulation tissue from the feet to the buttocks, with the exception of a portion of both anterior thighs. (See figure 4.)

The wet dressing regime was used as in case 1. Due to the great extent of raw surface, intravenous pentothal was needed each day when the fine mesh gauze dressing next to the granulations was removed.

In a burn of this extent large sheets of continuous skin would be impractical. Consequently the postage stamp method of split skin grafting was

Fig. 4.—Mr. S., preoperative. The legs looked like a "skinned rabbit" with 600 square inches of granulating surface.

decided upon, since it yields the greatest surface coverage for the least amount of skin. Epithelium can grow out from each of the four sides of a split skin graft.

The patient's granulating surfaces had cleared up enough for initial surgery by February 25, 1950. The patient was placed in a prone position on the operating table and anesthetized. The entire back from the shoulders to the buttocks was scrubbed with soap, water, alcohol, and ether. By means of the Padgett dermatome six drums of skin were taken from the back, each 10 by 20 cm. The entire back was dressed with a pressure dressing with a single thickness of fine mesh scarlet-red gauze next to the donor sites. The patient was then transferred from the operating table to the Hawley table, placed on his back, and his feet attached to the foot plates of the table. Meanwhile the skin grafts were laid on stiff vaselinized paper and stretched to open tissue spaces. These grafts were cut in strips and the strips cut in squares, giving approximately 32 squares per graft, making a total of 192 one inch squares of separate skin. Wet dressings were then removed from both legs, and the extremities were scrubbed with soap, water, and alcohol followed by irrigation with normal saline solution. A dry five yard roller was wrapped on the extremities to dry the granulations, and then removed. The granulations were next covered with topical bovine thrombin solution. The 192 squares of skin were dipped in plasma solution and pasted over the granulation

area with spaces of 1 to 2 cm. between adjacent squares. These were further fixed with a single thickness of fine mesh gauze previously dipped in normal saline solution. Over this, wet five yard roller gauzes were rolled incorporating about 10 Dakin's tubes for each extremity. The rollers were then covered with large abdominal pads and Ace bandages with the ends of the tube protruding so the dressings could be kept wet. Each extremity was placed in a wire basket for immobilization. It was impossible to skin graft the buttocks at this time. One thousand centimeters of blood were given during surgery, and the patient was returned to his room in good condition.

The initial dressings were done on March 7, 1950, ten days postoperatively. The dressings were changed under anesthesia. It was found that all the grafts had taken from 95 to 100 per cent. Both legs were washed with hydrogen peroxide, dried, and the pressure dressings reapplied with catheters in place for wetting the area. The back dressing was changed, and it was found that the donor sites were almost completely healed. A few raw spots were covered again with scarlet-red dressings.

Two weeks postoperatively the patient's extremities were once again started on the wet dressing regime to prepare the remaining granulating surfaces for skin grafting. By this time the previously applied skin grafts had healed satisfactorily and were starting to spread around their periphery. The patient was kept on a Stryker frame during the postoperative period to facilitate turning and handling and to avoid pressure sores.

The patient was returned to surgery on March 25, 1950. Four drums of skin each 10 by 20 cm. were taken from the abdomen and chest regions. Granulating surfaces were prepared for surgery in the usual manner. Bovine thrombin was squirted on the granulating surface. Skin grafts were backed with stiff vaselinized paper and cut into odd shaped sections varying from 1.2 cm. to 8 cm. in length. The raw surfaces were bathed with plasma, and the grafts were placed on granulating surfaces so as to get the greatest possible skin coverage. The grafts were held in place with fine mesh wet gauze and wet pressure dressings. Catheters were incorporated in the dressings. Donor sites were dressed with fine mesh scarlet-red gauze dressings.

These grafts also took nearly 100 per cent, and were sufficient to complete the healing of what was

Fig. 5.—Mr. S. Postoperative views showing healed skin grafts on legs. Patient wears elastic bandages to help support circulation while up.

3,600 square centimeters of granulating surface. The patient had two bouts of serum hepatitis, probably from the plasma, during his hospital stay. He had received 29 transfusions of plasma and blood. (See Figure 5.)

He was discharged from the hospital on June 20, 1950. His legs were completely healed about one month after the last operation, and he regained 100 per cent function at the knees and ankles. The grafts had softened and the legs began to fill out. He wore Ace bandages for support of circulation while erect and continued to do so until the superficial leg circulation recovered.

Summary

The best dressing for any granulating surface, over four weeks of age, or more than 5 cm. in diameter, is a split-thickness skin graft. If it is possible to get skin coverage on a granulating surface, early infections, deep scar contractures, or carcinomata can be avoided. Two cases are reported which exemplify the principles of rational burn therapy.

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759 North Milwaukee Street.

TWO LECTURES BY PSYCHIATRISTS SCHEDULED FOR MAY 1 AND 8

The Neuropsychiatric Services of Wood Veterans Administration Hospital and the Milwaukee Veterans Administration Regional Office are the sponsors of a series of lectures by outstanding psychiatrists. The first two lectures were presented on March 25 and April 9. The two remaining lectures are scheduled for May 1 and May 8 at 12:30 in the Hospital Annex of Wood Veterans Administration Hospital. "Clinical and Interpretive Aspects of Some Manifestations of Depression" is the title of the May 1 talk which will be given by Dr. R. Burke Suitt, who is associate in neuropsychiatry at Duke University School of Medicine. Speaking at the May 8 meeting, Dr. Karl M. Bowman, professor of psychiatry at the University of California Medical School, has chosen "A Study of Children Brought Before the Juvenile Court in Connection with Sex Offenses" as the subject of his paper.

The Treatment of Acute Laryngotracheobronchitis*

By HOWARD C. HIGH, JR., M. D.
Milwaukee

LARYNGOTRACHEOBRONCHITIS is a disease of infants and growing children—a fulminating, acute infectious process which affects the larynx and lower respiratory tree. It is characterized by severe sepsis, laryngeal obstruction, bronchial exudation, a rapidly progressive course, and often termination in death by asphyxia unless vigorous methods are rapidly and effectively applied. A sharp differentiation between "croup" and this disease is not possible. "Croup" usually implies a paroxysmal, hoarse, nocturnal cough and mild stridor occurring occasionally in infants with moderately severe upper respiratory infections. The condition is usually self-limited and general supportive measures suffice for its control. Acute laryngotracheobronchitis on the other hand is progressive, and its outcome is very often fatal.

The purpose of this paper is to present a plan for treatment of these cases. Everyone concerned should know "the master plan," and the organization of a definite logical procedure will best serve these seriously ill children.

An understanding of anatomy and physiology is essential in planning logical treatment. The chief predisposing cause is age. In young children there is abundant, loose areolar tissue in the larynx and subglottic area. The lumen of all the air passages below the larynx is small and easily occluded by the thick, gummy exudate and edema characteristic of this infection. An exudate 1 mm. thick in a 2 mm. bronchus will completely occlude it; whereas, such an exudate in a 4 mm. lumen still leaves a 2 mm. airway. In addition, an infant does not have the power in a cough sufficient to loosen and remove these secretions. Tracheal and bronchial mucosa becomes edematous and causes additional obstruction. It is not hard to see how complete occlusion and death can occur if rapid relief is not obtained.

Infants and children contract upper respiratory infections before they have developed any natural immunity. Rickets, scurvy, and other deficiencies common in infants make them more susceptible to these infections. Lack of humidity in overheated homes during cold weather, and drying of mucous membranes, is contributory to the onset of upper respiratory infections.

For ease of consideration the treatment will be divided into three categories; supportive, specific medical measures, and surgical procedures.

Supportive

These little patients are septic and this, coupled with the hard work they must do to breathe, quickly exhausts them. They must be kept as quiet as possible without the use of opiates. Morphine and codeine are absolutely contraindicated, because the cough reflex must be preserved. Atropine must be avoided as it causes drying and thickening of secretions which we are trying to combat.

With the high fever and rapid respiration, dehydration quickly results. Intake must be carefully checked, and subcutaneous or intravenous fluids freely given to keep the patients adequately hydrated. High humidity is probably the single most important supportive measure. A number of methods of increasing humidity have been used. The steam kettle is an old stand-by but not as helpful as a cool humidifier, such as the Walton. The purpose is to saturate the immediate surrounding air, yet keep the temperature between 70 to 75° F. If hot steam is used, the temperature in a small room will frequently be above 90° F. At this temperature, a tremendous amount of moisture is required to saturate the air. This makes breathing all the more difficult, and the discomfort of both patient and attendants in such an atmosphere is acute. The patient should be in a small room with the windows and the door closed so that the proper conditions can be attained.

Another method for increasing the humidity is the simple nebulizer, such as is used for penicillin. Using an oxygen tent over a crib, the nebulizer can be filled with water, and oxygen employed from a tank to spray a fine mist into the tent. This will also increase available oxygen, which is important. A direct connection of such an apparatus to the tracheotomy tube after tracheotomy was described by Albers.[1]

Boies[2] describes another simply constructed apparatus for increasing humidity without raising the temperature in the room. The deVilbus atomizer is used with a small oxygen tent and works very efficiently.

Whole blood transfusion is an excellent supportive measure. Some believe that specific immune bodies contained in adult blood may be beneficial in fighting the toxicity of the infection.

Specific Medical Procedures

On throat cultures Hemophilus influenzae, as well as the Staphylococcus and Streptococcus, is usually found. We feel the H. influenzae bacillus is probably the initial organism, and that the Staphylococcus and Streptococcus are secondary invaders.

Davison[3] has stressed the late appearance of secondary infection with the Staphylococcus. He feels this often happens in cases requiring tracheotomy as the result of trauma to the tracheal and bronchial mucosa with the suction catheter.

* Presented before the One Hundred and Tenth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1951.

H. L. Baum,[4] A. H. Neffson,[5] P. E. Howard,[6] and P. B. MacCready[7] have all studied the effects of the sulfa drugs on this disease. In general, they agree that these drugs are helpful but not specific.

Baum[5] and Howard[6] both use concentrated human plasma to help reduce laryngeal edema. We have had no experience with their method; nor have we tried the use of 50 per cent glucose given intravenously. These measures have been useful in their hands, but, since the antibiotics have been available, the use of concentrated plasma and glucose is not as necessary.

Everett,[9] after studying 1,175 cases of acute laryngotracheobronchitis in which 98 tracheotomies were done, feels that the single most important factor in treatment is the antibiotics. He states that all his patients received penicillin, sulfadiazine, and streptomycin.

Sodium and potassium iodides are employed to help liquefy bronchial secretions. In infants 3 drops of a saturated solution is given three times a day; for a child of two years, 5 drops of the same solution is given.

We give these patients 300,000 units of aqueous penicillin and 250 mg. of streptomycin when they are admitted. This penicillin may be repeated every 12 to 24 hours, and the streptomycin every 12 hours. There is now available a single product containing 300,000 units of aqueous penicillin and 500 mg. of streptomycin. This combination would be useful in an older child, but 500 mg. of streptomycin in a single dose is too much for an infant. If our original throat cultures do not show H. influenzae, the streptomycin may be discontinued.

Surgical Procedures

Laryngoscopy.—The first thing to be determined is the site of the respiratory obstruction. When the child is first examined, the epiglottis can be seen by using a tongue blade. If the epiglottis is fiery red and edematous, the cause of the obstruction is obvious, and a tracheotomy is probably going to be necessary. If, on the other hand, the epiglottis is normal, then we must look further for the cause of the trouble. The larynx itself and the immediate subglottic area is a likely site for the obstruction. We feel a direct laryngoscopy is necessary, but we are always prepared to proceed with a tracheotomy. It is helpful to have a small bronchoscope available when the larynx is inspected, so that it can be quickly slipped into the trachea if the child suddenly becomes more obstructed. If the glottis is open and no subglottic edema is seen, tracheotomy will not help. A bronchoscope should then be employed for inspection of the trachea and main bronchus. If no foreign body, mucus plug, or other main bronchus obstruction is found, then we are most likely dealing with bronchiolitis or obstruction of smaller bronchi. This condition can produce the signs and symptoms of upper respiratory obstruction including indrawing of the suprasternal notch and epigastrum. It is a difficult diagnosis to make without a complete, careful inspection of the tracheobronchial tree. When this condition is present, medical management, including high humidity and the antibiotics, is the only thing that will help. Mortality is higher in these cases than in acute laryngotracheobronchitis.

Intubation.—Any tube which remains within the larynx acts as a foreign body and irritates the delicate laryngeal mucosa. Obviously an intubation tube would hinder healing. Also it is difficult for a young patient to cough up secretions, whereas a nurse can easily aspirate them through a tracheal cannula. Baum[4] is the only one who still uses intubation in preference to tracheotomy. The work of the Jacksons,[10] Hollinger,[11] Richards,[10] and others all indicates that early, low tracheotomy is the safest plan.

Tracheotomy.—The decision for or against tracheotomy is not an easy one. We have all seen cases where we felt it would be necessary in a short time, only to have the child improve without it. We have also seen cases where surgery has been delayed too long. Provided we have the opportunity of seeing these cases before emergency intervention is necessary, we think the most important factor is the history. If the child has been sick less than 12 or 18 hours, and the course has progressed rapidly from mild stridor to impending asphyxia, a tracheotomy should be done without delay. A rising pulse rate is also an important sign. It may be the only indication of impending collapse. Sepsis, dehydration, and respiratory rate must be carefully evaluated. If tracheotomy is delayed until cyanosis is present, it may be too late. These children are septic and exhausted from the hard work of breathing so that even an open airway provided by tracheotomy may not save their lives.

We always introduce a small bronchoscope before doing a tracheotomy. It furnishes immediate respiratory relief, proves a means of aspirating dammed up secretions, and makes the operation an orderly surgical procedure. Tracheotomy below the second tracheal ring is essential if late complications such as laryngeal stenosis are to be avoided. If a high tracheotomy is unavoidable as it sometimes is, a second operation should be done within two or three days when the child is in better condition. The first incision can be closed and the cannula introduced into the trachea as low as possible.

Tracheotomy not only provides immediate relief from the airway obstruction, but permits good postoperative care. Nurses must be given special instructions in the care of these cases. A suction machine should be at the cribside and all personnel must know how to use it. Carefully done, adequate bronchial aspiration can be accomplished through a tracheotomy tube. Various solutions have been used to keep the tracheal and bronchial secretions from becoming inspissated: 1:10,000 adrenalin in saline, 5 per cent sodium bicarbonate, and plain saline are the most frequently used. Our own feeling is that the simple saline is as good as anything. Five to 10 cc. of the solution is instilled into the tracheotomy

tube with the child in a semi-Fowler's position. The patient is allowed to cough for 15 to 20 seconds, then is put into Trendelenburg position, and the trachea aspirated with a soft rubber catheter. A bronchoscopic set-up should always be at hand. A bronchoscope can be introduced through the tracheotomy opening after removing the tracheotomy tube, and plugs or casts of secretion can be removed with bronchoscopic forceps. In recent years, due to better methods of humidification, this is seldom necessary.

High humidity is as essential after tracheotomy as before. These children no longer have the benefit of the nose and throat to warm and moisten inspired air, and crusting is much more likely to occur if the surrounding atmosphere is not saturated with moisture.

Pneumothorax is a possible complication of tracheotomy. Neffson[12] and Everett[9] both found a reduction in this complication when the operation was done with a bronchoscope in place. This has also been our experience.

In favorable cases the fever should drop within 72 hours, and one should be able to remove the tracheotomy tube in 10 to 14 days if a low tracheotomy has been done.

Case Review

We have recently reviewed the cases of acute laryngotracheobronchitis requiring tracheotomy which were seen at Milwaukee Children's Hospital between 1937 and 1950. During this 13 year period there were 65 tracheotomies performed. Forty-four of them were done for acute laryngotracheobronchitis, and the others for such conditions as foreign body, retropharyngeal abscess, postoperative cleft palate cases, trauma, tetanus, and hemophilia. In the complete series there were 15 deaths, a mortality rate of 23 per cent. In the 44 cases of acute laryngotracheobronchitis there were 11 deaths, a mortality rate of 25 per cent.

Twenty-seven cases, or 60 per cent were in children under three years of age. Eight of the 11 fatal cases were in this same age group. On 7 of the 44 patients a tracheotomy was performed with a bronchoscope in place. There were no deaths in this group.

In the early years covered by this study, no chemotherapy was available, and the mortality rate was 50 per cent. When Prontosil and Neoprontosil were used, the death rate dropped to 33.5 per cent. In later years with sulfadiazine and the antibiotics the mortality figure has been about 10 per cent.

This is a small series of cases and no hard and fast conclusions can be drawn; but our treatment is certainly better, and the disease does not carry as serious a prognosis as it once did.

Comments

Earlier in the paper, we mentioned a "master plan." We feel such a plan can be formulated and made to function in every hospital. Often these little patients are true emergencies, and if all concerned know what to do, valuable minutes can be saved. Some member of the hospital staff should be made responsible for outlining a series of lectures and discussions for nurses, aids, and orderlies. Interns and residents, if present, can be responsible for setting the plan in operation when necessary. It would be desirable to have an otolaryngologist available to handle the endoscopy and tracheotomy if it becomes necessary. A capable pediatrician or internist can contribute his knowledge and help with the medical aspects.

Such a plan, once organized, might include the following steps:

A. *On Admission*
1. Mosher life saving tube in receiving room.
2. History. Progression of symptoms since onset.
3. Examination. Signs and symptoms of respiratory obstruction.
4. Throat culture.
5. Antibiotics.
6. If tracheotomy imminent, notify operating room.

B. *After Admission*
1. High humidity.
2. Pulse and respirations. Record every 15 minutes first hour.
3. Sedation. Barbiturates only. No opiates.
4. Chest x-ray. Patient's condition permitting.
5. Expectorants.
6. Transfusion.

C. *Tracheotomy: Postoperative*
1. Keep tracheotomy wound clean and watch for bleeding.
2. Keep inner tracheotomy tube clean.
3. Suction apparatus at bedside.
4. Bronchoscopy set available.
5. Tracheotomy set and replacement tube available.
6. Continue high humidity.
7. Continue antibiotics.

324 East Wisconsin Avenue.

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WISCONSIN ANTI-TUBERCULOSIS ASSOCIATION ANNUAL MEETING TO BE HELD MAY 15, 16

Dr. Richard P. Jahn, clinical instructor in medicine at Marquette University School of Medicine, will be one of the chief speakers when the Wisconsin Anti-Tuberculosis Association holds its annual meeting Thursday and Friday, May 15 and 16, at the Hotel Schroeder, Milwaukee.

Dr. Jahn will speak at 3 p.m. Friday on modern treatment of tuberculosis with emphasis on drug therapy.

Dr. Karl H. Pfuetze, medical director of the new Chicago State Tuberculosis Hospital, will talk at 2 p.m. Friday on patient-physician relationship. The subject will then be discussed from a local viewpoint by Dr. Ellison F. White, medical director of Wisconsin State Sanatorium, Wales, and Dr. M. W. Stuessy, general practitioner from Brodhead.

The future of the tuberculosis movement will be the topic of Dr. Howard M. Payne, professor of medicine, Howard University School of Medicine, Washington, D. C. Dr. Payne is also vice president of the National Tuberculosis Association.

Robert D. Coghill, Ph. D., director of research for Abbott Laboratories, North Chicago, Ill., will talk at 3:30 p.m. Friday on methods used to uncover new antibiotics active against the tubercle bacillus.

Other program highlights are:

Thursday:

9:30 a.m. Keynote talk, Dr. William Clyde Donald, II, chaplain, Deaconess Hospital, Milwaukee.

10:30 a.m. Panel of former TB patients discussing TB problems from patient's viewpoint.

Noon luncheon Talk by Dr. William Arkwright Doppler, executive secretary, New Jersey Tuberculosis League, on the job ahead for TB control workers.

2:00 p.m. Panel of Wisconsin authorities discussing TB problems from their viewpoints.

3:30 p.m. A talk on new trends in medical social services.

7:30 p.m. Business meeting—public is welcome; talk by Clarissa E. Boyd, director of field organization and program for the National Tuberculosis Association.

Friday:

9:00 a.m. Group meetings on nursing, social service, rehabilitation, health education, Christmas Seal sale.

Duodenal Obstruction from a Gallstone

Review and Report of a Case

By C. F. BRODERICK, M. D.
Wisconsin Dells

THE perforation of gallstones into some portion of the intestinal tract is an entity seen fairly often by surgeons. Batholin in 1654 published the first report of gallstone perforation into the intestinal tract. Obstruction of the bowel by gallstones is slightly more rare, and obstruction at the duodenum is quite rare—only 15 having been reported in all the medical literature. Although the perforation usually occurs in the duodenum, the obstruction is most often at the ileocecal valve.

In 1877 Murchison first described the occurrence and frequency of perforation of calculi into the intestinal tract. Courvoisier in 1890 analyzed 131 cases; VonWagner in 1911 analyzed 334 cases. Foss and Summers in 1942 analyzed 150 cases; they found the stone in the duodenum only six times. Denneen and Broderick in 1950 analyzed 10 cases with duodenal obstruction in only one. Wakefield, reporting from the Mayo Clinic in 1939, gives 18 cases, with the stone found in the duodenum six times. Dulin and Peterson in 1939 also reported 10 cases, with one in the duodenum.

Until recently the occurrence of intestinal obstruction from any cause was a catastrophe, and the mortality rate was very high. Obstruction by gallstones carried a much higher mortality rate than any other type for several reasons. It usually occurs in older persons, there often are multiple stones, and some are not found. Since the advent of x-ray and antibiotics as surgical aids, the mortality rate is now nearly negligible.

Diagnosis is usually not difficult; the usual signs and symptoms of intestinal obstruction following an acute gallbladder episode should lead to the suspicion of this condition. Often the patient never had a previous gallbladder attack or only very recently noticed difficulty with his digestive apparatus. Rigler, Borman, and Noble discuss the x-ray findings and list the following criterion for a diagnosis of gallstone obstruction:

1. Air or contrast media in the biliary tract.
2. Direct visualization of the stone or indirect visualization of the stone by means of contrast media in the intestine.
3. Change in position of a previously observed stone.
4. The roentgen evidence of partial or complete intestinal obstruction.

The differential diagnosis is sometimes confusing because an acute coronary occlusion, a ruptured ulcer, or an acute pancreatitis could be very easily confused with a perforating gallstone. Usually there is no fever and the occult blood does not persist in the feces. The blood pressure falls, and the pulse becomes slower due to the pressure of the gallstone passing. Both, however, quickly recover within 24 hours if the stone enters the intestinal tract and the pressure is freed. There may be profound collapse in the initial stage, but this collapse does not persist as in acute pancreatitis.

Report of Case

Mrs. M. W., a 74 year old white female, was first seen on Sept. 5, 1950. She was suffering with acute epigastric pain. About one month previously her physician had told her that she had gallbladder trouble. Her blood pressure at that time had been 210/100. When seen in this attack, the blood pressure was 170/90; the pulse was 84; and her temperature was 98.6 F. Chest was negative; heart sounds were good, although there was rigidity over the entire upper abdomen; and gurgles were heard. Relief of pain was obtained by giving 100 mg. of Demerol.

The patient was seen the next day, and there was practically no pain. The abdomen was soft, the blood pressure was 170/80, pulse 76, and the temperature 98.6 F. However, the patient was vomiting. The vomiting persisted every time she tried to take anything by mouth. She was hospitalized, and a Wangensteen suction inserted.

Physical examination was essentially negative with the exception of some epigastric pain on deep palpation. Laboratory examination revealed the following:

Urinalysis, sugar 4 plus and otherwise normal; red blood cell count 3,860,000; hemoglobin level 11 Gm., 70 per cent; white blood cell count 7,500; stabs 1; segments 70; lymphocytes 24; neutrophils 71; eosinophils 1; basophils 3; and monocytes 2. Blood sugar was 111 mg. per cent, and nonprotein nitrogen was 42 mg. per cent. Gastric contents showed 2 plus occult blood, free hydrochloric acid 19, and total acid 24. The icterus index was 10 units, and the Wassermann reaction was negative. The sedimentation rate was 26 mm. in one hour (Culter method). The electrocardiogram showed moderate myocardial disease in the form of a low T wave in lead 4.

A scout x-ray film of the abdomen, made with a bedside unit, showed gaseous distention of the stomach and a soft rubber catheter coiled in the fundus of the stomach. In the right upper quadrant, there was a vague suggestion of a laminated density. There was no appreciable gas in the small bowel.

The suction tube was again identified by fluoroscopic examination with its tip coiled in the fundus

of the stomach. A thin mixture of barium was then given, revealing an entirely normal appearance of the stomach, with the exception of the prepyloric region which appeared slightly narrowed. When the patient was placed on her stomach, the barium left the pyloric canal without great difficulty and was divided into two streams which diverged around the margins of a round object, about 4 cm. in diameter, which was actually within the lumen of the duodenal bulb. During the period of observation, only a small trickle of barium entirely passed this obstructing lesion. Films showed, in addition, concentric lines of calcification within the intraluminal object.

Discussion

The finding of a foreign object in the first portion of the duodenum raises several diagnostic possibilities. These may be enumerated as:

1. A gastric pedunculated polyp.
2. A primary tumor of the duodenal bulb.
3. A large gallstone.

The finding of concentric lines of calcium density is certainly in favor of the latter. One may thus deduct that the gallstone gained entrance to the duodenum by means of a fistulous communication between the gallbladder and the first portion of the duodenum.

Fig. 1.—The large mass in the duodenum outlined by barium.

The diagnosis was an intestinal obstruction in the first portion of the duodenum, due to a 4 cm. gallstone reaching the duodenum by way of a cholecystoduodenal fistula. (See figure 1.)

Duodenotomy was performed. The abdomen was opened by a right para median incision. The duodenum was found and opened longitudinally; a large gallstone (see figure 2) was removed and the duodenum closed vertically. An opening to the gallbladder into the duodenum was found on the posterior wall and admitted the tip of the little finger.

Fig. 2.—The large gallstone which was removed.

The omentum was sewn over the incision in the bowel, and the abdomen was closed in layers without drainage.

The patient made an uneventful convalescence and was discharged from the hospital 10 days after surgery. She has gained weight and has been very well up to the present time.

Dells Clinic.

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Intestinal Obstruction of Proximal Ileum Due to Gallstone

Report of a Case

By B. I. PIPPIN, M. D.
Richland Center

THIS patient, Mrs. F. C., a white woman, age 58, and weighing 168 pounds, lived on a farm where she attended to the duties of the house and did much of the farm work, such as milking, harvesting of crops, caring for chickens, lawn and flowers.

There had been no history of stomach, gallbladder, or digestive disturbances except in June 1950, when severe epigastric pain with nausea and vomiting developed. After one hypodermic injection of morphine (15 mg.) and atropine (0.4 mg.), she was soon relieved of her pain. She remained indoors for 24 hours, then proceeded with her usual duties in her home and on the farm.

A year later, on June 27, 1951, she was brought to the hospital following an acute episode of nausea, vomiting, and abdominal pain. The abdomen was distended with gas, but no masses were felt. Nothing else of significance was found on physical examination. Electrocardiogram was within normal limits; erythrocyte count 4,500,000; white blood cell count 15,400; and hemoglobin level 100 per cent. The urine was negative.

A Wangensteen tube was placed, and fluids and glucose were given intravenously to sustain the patient until a diagnosis could be made. Barium enema and x-rays revealed no obstruction of the large bowel. Flat x-ray showed marked distention of the small intestines indicative of obstruction, but we were unable to decide at what location. Evidence of foreign body was not visible.

On June 28, 1951 the patient was operated on and a mass the size of a large egg was found obstructing the ileum, approximately 18 inches from its proximal end. The mass had the appearance of a gallstone. It was composed of cholesterol and bile pigments, which confirmed the original impression. The gallbladder area was surrounded by firm fibrous adhesions, and a portion of the duodenum was imbedded in the mass where the stone evidently penetrated its wall.

Ileostomy to relieve the tension and drain the proximal bowel was performed, and the stone was then removed. Recovery was uneventful.

Comment

A gallstone is a rare cause of intestinal obstruction. This case is unusual also because of the absence of symptoms for so long a period of time in the presence of such gross pathology.

The Pippin Clinic.

1952 ESSAY CONTEST ANNOUNCED BY AMERICAN SOCIETY OF PLASTIC AND RECONSTRUCTIVE SURGERY

The Foundation of the American Society of Plastic and Reconstructive Surgery offers awards in junior and senior classifications for original contributions in this field.

Junior Classification: Two six month scholarships in leading plastic surgery services in the United States, England, and Italy will be awarded.

Senior Classification: The Foundation's annual prize, a silver plaque, will be given for the best essay presented at the annual meeting of the Foundation.

The contest is restricted to residents and surgeons in the practice of plastic and reparative surgery for not longer than five years. The subject matter of the essay should be the result of some original clinical or laboratory research in plastic surgery of recent date. All essays should be submitted in quadruplet form in English with no indication of the writer's name or his institutional affiliation, but should be identified by a legend. This legend should appear on the outside of a sealed envelope which contains the name, address, and affiliations of the contestant.

All entries must be received by the award committee not later than September 1, 1952. Further inquiries should be addressed to: The Award Committee, % Jacques W. Maliniac, M. D., 11 East 68th Street, New York 21, New York.

Central Lumbar Disk Simulating Cauda Equina Tumor Occurring in a Twelve Year Old Boy with Dyschondroplasia

By JOHN J. VAN DRIEST, M. D. and HARRY P. MAXWELL, M. D.*
Sheboygan Milwaukee

IT HAS become apparent in recent years that surgical intervertebral disk lesions occur in children. The recent article by Key[1] substantiates this idea. He reported 4 cases in which lumbosacral disks were removed with complete remission of symptoms. His patients were a girl 12 years of age, a girl 14 years of age, and two 18 year old boys. In a series of 1,217 patients operated on for intervertebral disk lesions at The Mayo Clinic, as reported by Love,[2] 25 or 2.1 per cent of the patients were between 10 and 19 years of age. Wahren[3] also reported a 12 year old girl who had a typical lumbosacral disk lesion.

The case we wish to report occurred in a 12 year old boy where diagnosis was difficult because he also had dyschondroplasia.

Report of a Case

R. G., a 12 year old boy, was admitted to Milwaukee Children's Hospital on October 11, 1948 on the service of Dr. A. C. Schmidt. He was born at term with abnormally wide and short hands and feet. He developed more slowly, both physically and mentally, than normal. He was a member of a special class for the mentally retarded at his school and was not as physically active as other boys his age. In August 1948, the patient fell, but it is not known if he hurt his back at this time. He complained of pain in his right knee. The pain persisted, and during the next month a list to the right also developed.

He was mentally retarded; his hands and feet were short and broad, and his tongue was abnormally thick. He had a list to the right and tenderness over the lower lumbar spine. The spine was angulated forward at the dorsolumbar junction. Percussion over the third and fourth lumbar caused pain in the right knee. The Lasègue test was positive on the right, and there was limitation of straight leg raising. Jugular compression increased the pain in his right knee. The knee jerks were diminished, but equal. The achilles reflexes were absent bilaterally. Babinski's sign was absent. Sensation was normal. The supinator, pronator, and dorsiflexor muscles of the right foot were weak. Because of poor cooperation, lumbar puncture was done at the third lumbar under ether anesthesia. The spinal fluid pressure was 350 mm. of cerebrospinal fluid; and the rise and fall of pressure on the jugular compression were rapid. There were 155 cells of which 12 per cent were polymorphonuclear leukocytes, and 88 per cent were lymphocytes. The globulin (Pandy reaction) was mildly positive; total protein was 40 mg.; sugar was 61 mg.; colloidal gold curve was 1222221000; and the Wassermann reaction was negative. The basal metabolic rate was –8 per cent. Urinalysis, sedimentation rate, blood phosphorus, and cholesterol determinations were normal.

The patient was treated by bed rest, physiotherapy, and traction for one month with no appreciable improvement in symptoms. One of us (H.P.M.) then saw the patient in consultation.

Lumbar punctures under pentothal anesthesia at the fifth lumbar-first sacral, fourth-fifth lumbar, and third-fourth lumbar interspaces yielded only a few drops of xanthochromic fluid. Fluid was easily obtained at the first-second lumbar interspace. The initial pressure was 210 mm. of cerebrospinal fluid, with rapid rise and fall on jugular compression. Three cubic centimeters of Pantopaque were injected, and a complete block was visualized at the second-third lumbar interspace.

A cauda equina tumor was suspected, and a laminectomy was performed on November 15, 1948 under ether anesthesia. The laminae of the second lumbar and the third lumbar were removed. The dura was opened, and the spinal fluid was seen to be under great pressure. The nerve roots were greatly swollen, reddened, and matted together. A catheter passed cephalad revealed no obstruction, but caudally obstruction was met at the fifth lumbar. The lamina of the fourth lumbar was then removed, and a rubbery tumor mass was palpated on the floor of the spinal canal between the fourth and fifth lumbars. The bulging fibers of the cauda equina were separated in the mid-line; the mass was identified and incised. Typical nucleus pulposus material spontaneously extruded through the defect into the operative field. One large and several small pieces were removed; the largest was 2.0 cm. by 1.0 cm. by 0.5 cm. The dura mater was closed with some difficulty over the swollen nerve roots.

The immediate postoperative course was uneventful, and the patient has had complete, immediate, and lasting relief of the pain in his right knee to the present time (April 1, 1952). The list has disappeared, but the forward angulation has persisted.

* Assistant clinical professor, division of neurological surgery, department of surgery, Marquette University Medical School.

Summary

A case of a large, centrally placed fourth-fifth lumbar surgically treated herniated intervertebral disk in a 12 year old boy with dyschondroplasia is reported. The lesion at the fourth-fifth lumbar produced a complete block to Pantopaque as high as the second-third lumbar from extreme secondary irritative inflammation and edema of the cauda equina. Intervertebral disk lesions with posterior protrusion do occur in childhood and adolescence, but the paucity of cases requiring surgery may be partially explained by liquefaction and absorption of the youthful herniated nucleus pulposus material.

(Maxwell) 208 East Wisconsin Avenue.

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WISCONSIN HEART ASSOCIATION TO MEET IN MADISON ON MAY 10

The annual meeting of the Wisconsin Heart Association will be held in Madison at the Wisconsin General Hospital on Saturday, May 10. Registration begins at 9:00 a.m. The program chairman for the meeting is Dr. Herman H. Shapiro, associate professor of medicine at the University of Wisconsin Medical School. The scientific session, which will consist of fifteen minute papers, is as follows:

Welcome—W. S. Middleton, M. D., Dean, University of Wisconsin Medical School

9:15 Prothrombin Determination—Walter Jaeschke, M. D., Madison

9:30 Experiences with Cardiac Catherizations in Congenital Heart Disease—Armin R. Baier, M. D., Milwaukee

9:45 Experiences with the Newer Anticoagulants—Royal Rotter, M. D., Madison

10:00 The Selection of Candidates for Mitral Valve Surgery—Howard L. Correll, M. D., Milwaukee

10:15 Recess

10:30 Psychosomatic Aspects of Heart Disease—Marc J. Musser, M. D., Madison

10:45 The Surgical Treatment of Mitral Stenosis—Henry F. Twelmeyer, M. D., Milwaukee; Forrester Raine, M. D., Milwaukee

11:00 Problems in the Rehabilitation of Cardiacs—Harry D. Bouman, M. D., Madison

11:15 Reevaluation of Cardiac Roentgenology—Nathan Grossman, M. D., Milwaukee

11:30–1:30 Luncheon Recess

1:30 Angiocardiography—Lester W. Paul, M. D., Madison

2:00 Corporation Business Meeting—Robin N. Allin, M. D., Madison, President, presiding
Election by Wisconsin Heart Association members of officers and board members. Brief annual reports.

3:00 Recess

3:15 Clinical Pathological Conference—D. Murray Angevine, M. D., Madison; Richard V. Ebert, M. D., Minneapolis

3:45 Clinical Pathological Conference—D. Murray Angevine, M. D., Madison; Leslie Kindschi, M. D., Monroe

4:30 Adjournment

6:00 Annual Dinner Meeting at the Park Hotel—Presentation of new officers

8:00 Open meeting for the public (Auditorium of the Service Memorial Institute)—Richard V. Ebert, M. D., Minneapolis

Wisconsin Anesthesia Study Commission of the Wisconsin Society of Anesthesiologists

Editor—DOROTHY W. BETLACH, M. D., Madison, Wisconsin

ATELECTASIS is a frequent pulmonary complication following surgical procedures and anesthetization. In one statistical analysis, a partial or massive collapse of the lung developed in 4 to 6 per cent of all surgical patients, while 14 per cent of the patients having laparotomies and herniorrhaphies had similar disturbances. Among the factors contributing to pulmonary morbidity is the preoperative condition of the patient. Those in whom acute or chronic pharyngitis existed before operation showed an incidence of more than 10 per cent of postoperative respiratory complications. The frequency was nearly double in cases with oral sepsis, and over 25 per cent of patients with cough had postoperative respiratory abnormalities. Other significant contributory factors included the injudicious use of heavy preanesthetic medications, failure to use belladonna derivatives before general anesthesia, uncorrected partial respiratory obstruction during anesthesia, respiratory depression with poor tidal exchange, and postoperative depression with inhibition of cough reflex as a result of pain, over-sedation, or shock. With prolongation of operating time, there was a marked increase in the incidence of respiratory complications.

The Wisconsin Anesthesia Study Commission presents the following cases to illustrate several of the factors responsible for development of atelectasis.

Report of Cases

CASE 34.—An apparently healthy 26 year old male was admitted for an elective inguinal herniorrhaphy. Physical examination revealed very poor dental hygiene with many broken teeth, injected gums, and post cervical adenopathy. Oral temperature was normal, and lung fields were resonant.

Blood pressure was 100/70 and pulse rate was 76 beats per minute. After premedication of 0.4 mg. of scopolamine, 150 mg. of 3 per cent surital (thioseconal) were given intravenously, and maintenance of anesthesia was continued with cyclopropane by to-and-fro absorption technic. Anesthesia time of 45 minutes was completely uneventful, and the patient was responding when he was returned to his room.

On the second postoperative day, his pulse rate increased to 100 to 120 beats per minute, and the temperature spiked to 102 F. There was dullness at the right lung base, and chest x-ray showed cloudiness at the right base which was interpreted as an early pneumonia or atelectasis. Tracheal intubation with aspiration of thick purulent mucus was performed the next day. There was immediate physical improvement, and breath sounds were clearly audible at the right base. Temperature and pulse rate returned to normal limits within 24 hours, and a progress x-ray showed marked clearing in the right lung field. Final diagnosis was atelectasis of the right lower lobe.

CASE 35.—A 32 year old white female of average height and weighing about 125 pounds received 8 mg. of morphine sulfate and 0.3 mg. of scopolamine as preoperative medication. Following induction with 300 mg. of 5 per cent sodium pentothal intravenously, she received 7.5 mg. of *d*-tubocurarine, and anesthesia was maintained with minimal amounts of cyclopropane by to-and-fro absorption technic. A salpingo-oophorectomy was performed during an uneventful anesthetic period of one and one-half hours. She was returned to her room at 9:30 a.m. and was awake and alert in one-half hour.

The following sequence of medication was given her in the next 30 hours:

10:00	a.m.	demerol, 100 mg.
10:30	a.m.	codeine, 60 mg.
2:10	p.m.	morphine, 15 mg.
4:40	p.m.	morphine, 10 mg.
8:30	p.m.	morphine, 15 mg.
12:30	a.m.	morphine, 10 mg.
4:30	a.m.	morphine, 15 mg.
7:30	a.m.	Empirin compound
12:15	p.m.	morphine 10 mg.
4:30	p.m.	morphine 15 mg.

The afternoon of the first postoperative day she complained of pain beneath the midsternum and to the right of the sternum. Temperature was 101.2 F. Physical examination revealed asymmetry of the chest with lag in excursion on the right, tracheal deviation to the right, and depression of breath sounds over the right lung fields. X-ray demonstrated massive atelectasis of the right lower and middle lobes. The patient was made to cough vigorously with dislodgement of considerable mucus. Throughout the night, she had inhalations of 100 per cent carbon dioxide for 2 to 3 minutes every 20 to 30 minutes. The gas was delivered from the tank by a hose held 6 inches from her face. Breath sounds became more audible on auscultation. The following morning tracheal intubation was performed with aspiration of more mucus and resultant increased clearing of the right lower lobe. Two days later, progress x-ray showed clear lung fields.

Comments

The first case illustrates very clearly the importance of the preoperative physical status of a patient. Here was a young individual who, in spite of healthy appearance, had definite oral sepsis. The poor dental condition served as a focus of infection with probable contamination of the respiratory system already existing before anesthetization. Prompt recognition and treatment of the atelectasis postoperatively plus chemotherapy prevented increased and prolonged morbidity. However, chemotherapy prior to operation might have prevented the pulmonary complications.

The woman was a relative of several members of the surgical staff. Overanxiousness on their part to prevent any discomfort was probably responsible for the overdose of opiates she received, a total of 90 mg. of morphine plus 100 mg. of demerol and 60 mg. of codeine in 30 hours. The overwhelming sedation set up a vicious train of events: marked respiratory depression, accumulation of secretions, and bronchial obstruction followed by absorption of air in the affected area of the lung with subsequent massive atelectasis.

Certain recommendations definitely are in order to prevent postoperative pulmonary complications and further reduce the incidence of such cases. All cases of acute respiratory infections should be postponed 1 to 2 weeks. Patients with recent irritations of the respiratory passages should be given larger doses of belladonna derivatives. Postural drainage and even preoperative bronchoscopy are recommended for persons with chronic respiratory disease. During operations, the lightest plane of anesthesia permissible should be maintained. Pharyngeal aspiration should be performed, if necessary, and in cases in which regurgitation occurs, immediate aspiration of the trachea or bronchoscopy must be done.

The necessity for competent supervision during the immediate 6 hours postoperatively cannot be overemphasized. Frequent stir-ups consisting of active change of position, vigorous coughing, and deep breathing are necessary. Pharyngeal secretions should be aspirated. Minimal use of narcotics is stressed. Small doses of opiates repeated every 3 to 4 hours are more effective than a single large dose which is also more depressing. Early mobilization and prophylactic chemotherapy also aid in prevention of complications.

Dependence upon drugs cannot replace careful preoperative examination and preparation, judicious administration of the anesthetic agent best suited for the individual, and vigilant supervision during the recovery period.

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SPRING SCIENTIFIC SESSION PLANNED BY ANESTHESIOLOGISTS

The Wisconsin Society of Anesthesiologists will hold its spring scientific session on May 4. The meeting will be held in the sixth floor lecture room of the Wisconsin General Hospital, Madison. The program is scheduled as follows:

10:15 Panel Discussion on "Anesthesia and the Diabetic Patient"—A. M. MacKay, Chairman
Main Speaker: Edwin C. Albright, assistant professor of medicine, University of Wisconsin

11:15 "Mechanical Respirator for Multiple Resuscitation"—O. S. Orth

11:30 "A Promising Drug in the Treatment of Prolonged Hemorrhage"—Joseph G. Strawitz

11:45 "Does Curare Increase Mortality?"—William H. L. Dornette

12:15 Recess for lunch. Hospital cafeteria is available but no formal luncheon planned

1:30 Report on Anesthetic Practice, 1951, "Madison Physician Anesthetists"—R. M. Wylde

2:00 Report on Anesthetic Practice, 1951, Wisconsin General Hospital—Evelyn Lipp

2:30 "Regional Anesthesia Illustrated"—L. G. Kilpatrick

3:00 "Provoked Hypotension to Decrease Bleeding"—Milton Davis, Jr.

3:30 Question and Answer Period—Gordon Garnett, Chairman

Proceedings of the Milwaukee Academy of Medicine, February 19, 1952

Myasthenia Gravis*

By LEE M. EATON, M. D.
Rochester, Minnesota

THE importance of myasthenia gravis lies not in the frequency with which it is encountered in medical practice but in the frequency with which it must be distinguished from other conditions that give rise to exhaustion and weakness. Although myasthenia gravis is encountered infrequently, its diagnosis is important since the majority of patients having this condition respond in a satisfactory manner to medical treatment. Myasthenia gravis is of great interest to the investigator who realizes that there is a relationship between myasthenia gravis and the endocrine system, even though he cannot see clearly what that relationship is. Perhaps myasthenia gravis is a key disease, the understanding of which will shed light on related problems of endocrine and metabolic nature.

During 1941, my colleagues and I decided that one of us should have an opportunity to study all cases of myasthenia gravis at the Mayo Clinic in an effort to determine whether or not thymectomy was of value in its treatment. I was given this opportunity which was unique in that I was permitted to see and treat an unusually large number of patients with this uncommon disease. During the first years of the study I should estimate that only a third of the patients coming to us had had a correct diagnosis. I have been interested in the reasons for failure to diagnose myasthenia gravis. I think we can attribute it first of all to lack of experience with the disease and, secondly, to misconceptions regarding the age of onset, the sex of the patient likely to have the disorder, and the seriousness of the disorder. These misconceptions stand in the way of proper diagnosis.

I am repeatedly surprised to learn that the patients who have myasthenia gravis seldom complain of feeling exhausted. Instead, they have specific complaints which describe the fatigability and weakness of specific muscles. The commonest initial complaints are those of double vision and drooping of the eyelids. Fifty-six per cent of our patients had these symptoms initially, and all but 6 per cent of the patients had these symptoms by the time they came to us. Approximately 28 per cent of the patients complained first of weakness of the muscles of the face, the mouth, and the pharynx and about 21 per cent first complained of weakness of the muscles of the neck or extremities.

There is a misconception regarding the age and sex of the patients with myasthenia gravis. Too many physicians think of it as a disease of young women. We have found that among the patients coming to the clinic with this disease there are as many men as women, and that the disease develops among as many patients who are more than 40 years of age as those who are less than 40. However, in the age group in which the onset of myasthenia gravis occurred before the age of 40 years, women predominated in the ratio of 2:1, while in the group in which the disease developed after the age of 40 years, men predominated in approximately the same ratio. In other words, myasthenia gravis is more likely to develop among men during the ages of 40 to 60 years than during the ages of 20 to 30 years.

Some physicians feel that the average patient having myasthenia gravis survives only a couple of years. Many of our patients have had the disease five, ten, or more than twenty years at the time we have seen them. The course is relatively benign in many cases, so benign that the disease is frequently not given diagnostic consideration.

The use of diagnostic tests with neostigmine, quinine, and curare was discussed in some detail. It was pointed out that almost always the tests with neostigmine serve to confirm the diagnosis of myasthenia gravis. In the group, however, in which diagnosis is most difficult, namely, those patients who give a history suggestive of myasthenia gravis but who on examination show no objective weakness, the value of tests with curare was emphasized. Equal emphasis was given to the danger of these tests, and they were not recommended for general use.

Myasthenia gravis and thyrotoxicosis are associated too frequently for the association to be merely coincidental. Approximately 3 per cent of our patients have been treated for thyrotoxicosis before symptoms of myasthenia gravis have developed. Approximately 3 per cent of our patients have both diseases simultaneously. Some have recovered from myasthenia gravis with treatment of thyrotoxicosis but not all have done so. The combination is a serious one.

Our work with Doctor Clagett has lead us to conclude that there is no statistical evidence that thymectomy changes perceptibly the course of myasthenia gravis. Consequently, we are not recommending thymectomy for treatment of myasthenia gravis.

(Continued on page 383)

* From the sections of neurology and psychiatry, Mayo Clinic, Rochester, Minnesota.

Clinicopathologic Conference

Editors—W. A. D. ANDERSON, M. A., M. D., Marquette University School of Medicine, Milwaukee and D. M. ANGEVINE, M. D., University of Wisconsin Medical School, Madison

PRESENTATION OF CASE*

Dr. Robert A. O'Connell: The patient was a 40 year old single white male laborer who entered this hospital for the first time on March 13, 1948. The chief complaint at that time was a marked dyspnea at rest and a pronounced edema of the lower extremities, sacral area, penis, and scrotum, all of two and one-half months' duration. Past history at that time revealed that a shortness of breath on heavy exertion was first noted in 1944 while the patient was stationed in France, but that it was relieved with rest and not present on light duty. The patient received a routine separation from the Army in 1945 with no evidence of dyspnea on the discharge physical. In December 1947 he developed an upper respiratory infection with a low grade fever, cough and effort breathlessness. Treatment by a private physician improved symptoms temporarily, but the cough and effort dyspnea persisted and increased in severity. In January 1948 progressive swelling of both ankles developed, for which a private physician gave the patient digitoxin and a low salt diet resulting in a slight temporary improvement in his condition. A productive cough persisted with rapidly increasing dyspnea, ankle edema, paroxysmal nocturnal dyspnea, and marked palpitation. About this time a generalized erythematous, pustular, papular rash with severe itching and burning developed. Subsequent admissions to the hospital in July 1949 and February 1950 were for cardiac and dermatologic symptoms. The patient admitted excessive drinking, averaging seven to ten glasses of beer daily for the past 14 years but denied using whiskey or wine.

The physical examination on each admittance was essentially unchanged. There was noticeable dyspnea and considerable coughing which was productive of excessive amounts of a whitish sputum. There was no venous distention of veins of the neck, and the lungs revealed extensive moist rales posteriorly and dullness to percussion at both bases. The heart was enlarged to the left and downward, the rate and rhythm were regular at 96, tones were distant, and there was a harsh, grade three, low-pitched, systolic apical murmur but no thrills. The blood pressure was 118/84. The described murmur was absent on the initial admission but developed in the course of the hospitalization and persisted through each subsequent examination. The liver was palpable four fingerbreadths below the costal margin with a firm, non-tender edge, and the spleen was palpable two fingerbreadths below the rib margin. There was a four plus edema of the lower extremities, scrotal and sacral regions, and some erythematous, patchy, discoloration of the legs but no cyanosis or clubbing. The skin examination revealed a papular, pustular rash over the abdomen, legs, back, and arms.

An extensive cardiac work-up was done with all the electrocardiograms showing myocardial damage on the basis of ST–T wave changes and a left strain pattern. The T waves were inverted in leads 1, 2, and 3 and in V4, V5, and V6 with slight ST–T depression in leads 1 and 2. (Fig. 1) Venous pressure was 24, arm to lung time was 21.5 seconds, and arm to tongue time was 37.5 seconds. The white blood cell count was 8,000 with a normal differential, hemoglobin was 15.5, sedimentation rate was 23, and the serology was negative as were urinalysis, blood cultures, and sputum examinations. Congo red test was normal. Liver and gingival biopsies were not diagnostic. The prothrombin time was 56 per cent, bromsulphalein retention was 16 per cent, the albumin 3.0 Gm. per cent, globulin 2.6 Gm. per cent, and the serum cholesterol was 436 mg. per cent. X-rays of the chest on the first admission revealed an enlargement of the cardiac shadow and extensive left-sided pleural effusion that showed subsequent resolution following repeated chest taps. The fluid obtained was brownish-colored and was negative for bacteria. A chest film on the last admission showed moderate cardiac enlargement and adhesions with a thickened pleura on the left side. At this time the urine and blood tests were still within normal limits, but the liver functions showed slight impairment as before. Electrocardiograms demonstrated no change over previous admissions.

On each admission the patient was treated with absolute bed rest, digitoxin, salt-free diet, mercuhydrin, and oxygen. Under this regime on the first two admissions there was a marked clinical response, and on each occasion he was discharged with a slightly palpable liver the only abnormal finding. During these times the cough, edema, and dyspnea were greatly relieved. He was afebrile throughout the entire hospitalization in 1948 and 1949, but on the last entry he had a fever of 100 F. The final course in the hospital was marked by a rapid increase in edema, dyspnea, cough, temperature, and a terminal oliguria. Despite mercuhydrin

* From the Department of Pathology, Veterans Administration Hospital, Wood, and Marquette University School of Medicine. **Dr. Robert A. O'Connell, Dr. Howard L. Correll, Dr. M. J. Lustok**, clinicians; **Dr. Leslie E. Jones**, radiologist; **Dr. J. M. Lubitz**, pathologist.

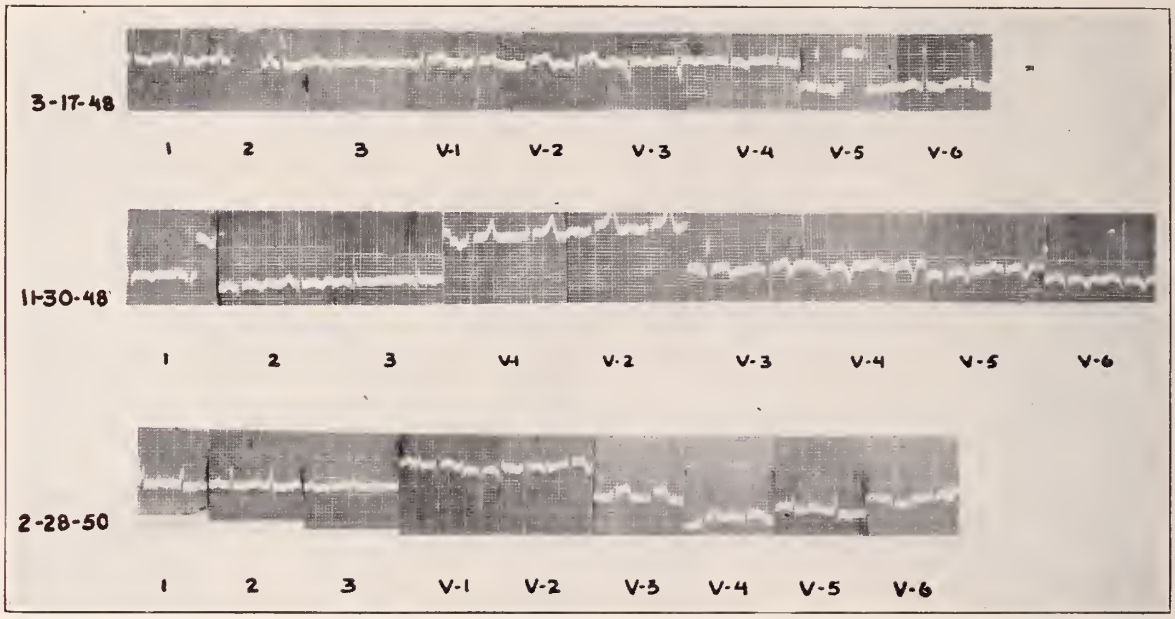

Fig. 1.—Serial electrocardiograms revealing alterations of T waves in the standard and precordial leads.

given intravenously and usual supportive therapy, the patient became comatose and expired on the evening of the fifth hospital day.

Dr. Leslie E. Jones: The x-rays on admission in March 1948 revealed an extensive pleural effusion in the left with obliteration of the left cardiac border. There apparently was marked enlargement of the cardiac shadow with pulmonary congestive changes throughout both central lung fields. Thoracentesis resulted in a decrease in the amount of pleural effusion but not enough clearing for evaluation of the cardiac shadow. X-rays done on May 17, 1948 showed some clearing of the pleural effusion and revealed residual pleural thickening and adhesions obliterating the left costophrenic sulcus. Cardiac fluoroscopy and teleroentgenograms done in June of 1948 showed an enlargement of the cardiac shadow involving primarily the left ventricle. The measured transverse diameter of the heart was 16.1 cm. as compared with a Ungerleider–Clark predicted diameter of 13.4 cm. The pleural effusion had cleared from the left base revealing residual thickened pleura and pleural adhesions. The changes in the left base showed a decrease of involvement as compared with the film of May 1948. On March 11, 1949 the film revealed a marked generalized enlargement of the cardiac shadow with residual thickened pleura in the left base. On March 21 the findings were essentially the same in the lower lung fields, and there was an increased density in the left apex which was compatible with a pleural effusion or pulmonary infarct. Examinations done on May 17, 1949 and July 14, 1949 revealed moderate enlargement of the cardiac shadow but no demonstrable congestive changes. There was residual thickened pleura in the left lower axillary region. A minimal area of pulmonary fibrosis was all that remained of the old infarct site in the left apex. On March 2, 1950 films taken at the patient's bedside revealed extensive pulmonary congestive changes with bilateral pleural effusion which almost completely obscured the cardiac shadow. There appeared to be generalized enlargement of the heart, however.

Clinical Discussion

Dr. Howard L. Correll: The history given appears to support either the syndrome of right heart failure or of recurring total heart failure of four years' duration. The picture of a right heart failure syndrome is not borne out by the prolonged arm to lung and lung to tongue circulation times recorded in this case. These findings and the clinical story do support the syndrome of total heart failure.

In general, if patients are under 40 years of age, the most common cause for the syndrome of total heart failure is rheumatic myocarditis. In patients over 40 the most common cause is myocardial infarction. But, while these are the two most common causes, one must also consider idiopathic myocarditis, virus myocarditis, or infectious myocarditis of other types; the group of collagen diseases including periarteritis, scleroderma, dermatomyositis and disseminated lupus erythematosus; the nutritional myocardoses and primary amyloidosis. Less common causes of total heart failure are persistent rapid heart rates of any type, and a peculiar type of diffuse myocardial necrosis or diffuse myocardial fibrosis resembling multiple microscopic infarctions. Lastly, there are certain syndromes which resemble total heart failure but are rather failure of blood to reach the heart. Constrictive pericarditis and chronic cardiac tamponade from chronic serosanguineous pericardial effusion are examples.

Rheumatic myocarditis would be the commonest cause for total heart failure in a person in this age group. This can be ruled out by the absence of any valvular heart disease and characteristic chamber enlargement.

Virus, isolated or infectious, myocarditis is next in importance from the standpoint of frequency. Doctor Lustok has found that a history of alcoholism and acute infection antedate the onset in a large proportion of this group. This patient had such a history as well as a history of recurrences. Chronic recurring idiopathic virus or infectious myocarditis cannot be eliminated as the responsible factor for heart failure in this instance.

Apparently at no time did the patient have scurvy or any bleeding phenomenon, but a nutritional myocardosis cannot be completely eliminated in the differential diagnosis.

Systemic amyloidosis was undoubtedly considered because the Congo red test was done and found to be negative. It is usually negative in primary amyloidosis and is of little value. A gum biopsy was done, apparently with the same diagnosis in mind and that too was negative, thus excluding this diagnosis in so far as possible.

Of the various collagen diseases there is nothing typical of periarteritis, dermatomyositis, scleroderma, or disseminated lupus. None of the associated evidences such as hypertension or eosinophilia are present. Tachycardias of various types are known not to be present and could not, therefore, have been the cause of heart failure in this patient.

Myocardial infarction would have had to be multiple, unless a septal infarction had occurred, and there was no electrocardiographic evidence of this. Perforation of a septal infarction may cause a systolic murmur and a progressive picture of total failure. This possibility is eliminated by the absence of the characteristic loud systolic murmur and palpable thrill as well as by the remissions. Subendocardial myocardial infarct and multiple myocardial infarcts are most unlikely in the absence of any distinguishing electrocardiographic characteristics.

With a constrictive pericarditis there is a small quiet heart. This heart was certainly not small and altered in size with the state of compensation. A constrictive pericarditis is not the cause for this man's heart failure. Mediastinal pericardial adhesions, which can occur with a large heart, would be a possibility, but again the heart apparently changed in size with the changing states of compensation and eliminated this possibility. Chronic recurring pericardial effusion, often serosanguineous in nature and usually seen in alcoholics with a vitamin C deficiency is a possibility less easily eliminated. This may cause chronic obstruction to the return of blood to one or both sides of the heart. It does not necessarily give the characteristic electrocardiographic changes of the chronic constrictive pericarditis and is not ruled out in this instance.

The large liver is very easily explained on the basis of total heart failure. One need not postulate the presence of cirrhosis though, of course, in an alcoholic, it may have been present. The depression in liver function tests is not at all uncommon as part of the picture of heart failure and is of no special significance other than an indication of chronic passive congestion of the liver. The spleen, which apparently was chronically enlarged, is probably significant of nothing more than a hypertension in the portal circuit. It is not evidence in favor of the collagen diseases any more than of any type of chronic heart failure.

In summary, this appears to represent total heart failure not due to the usual causes. Rheumatic myocarditis, myocardial infarctions, the collagen diseases, and amyloidosis appear to be ruled out. Ectopic tachycardias and mediastinal pericardial adhesions or constrictive pericarditis are not likely causes. Viral or other infectious myocarditis and nutritional myocardosis with chronic serosanguineous pericardial effusion have not been eliminated. Fluoroscopy for extent of cardiac pulsation would not be helpful in differentiating effusion from a dilated heart, such as occurs in the first two conditions, because the more the heart dilates the less the amplitude of contraction required to pump out a given volume of blood. Therefore, a dilated heart scarcely moves and approaches the quietness of a heart with a pericardial effusion. Other attempts at differentiation are usually as equivocal so further differentiation is usually not accomplished. Of these two possibilities the one most likely to me would be a recurring serosanguineous pericardial effusion with a chronic cardiac tamponade.

Dr. J. M. Lubitz: Would seven to ten glasses of beer a day be considered excessive in Milwaukee?

Dr. Howard L. Correll: Doctor O'Connell told me he was a heavy drinker and inferred that the story of seven to ten glasses of beer was abnormally conservative. He drank heavily, lived in rooming houses, and had a bad dietary history.

Dr. W. J. Smiles: Would it be possible for this patient to have had subacute bacterial endocarditis?

Dr. Howard L. Correll: This is a cause of the total heart failure syndrome by virtue of the myocarditis which develops but I doubt that petechiae, even the infected emboli, would give a recurring skin rash over a period of two or three years. The persistent lack of fever and three year duration of symptoms would also be unusual.

Necropsy Findings

Dr. J. M. Lubitz: Autopsy examination showed a patient with a feminine body habitus, consisting of narrow shoulders, broad pelvis, female distribution of pubic hair, and long tapering fingers. Dependent edema, particularly of the lower extremities, was pronounced. The legs, in addition to the edema, showed the dry eschars that probably were the result of the dermatitis mentioned clinically.

On internal examination the abdominal cavity contained 2,000 cc. of ascitic fluid. The liver extended about 4 cm. below the right costal margin.

The right pleural cavity contained 2,000 cc. of fluid and showed adhesions at the apex and at the diaphragmatic surface. The left pleural space was completely obliterated, and it is interesting to note the development of these adhesions following effusion by x-ray and clinically. The lungs were heavy; the right weighing 850 Gm. and the left 1,250 Gm. They showed intense hemorrhagic edema such as we find with severe heart failure. The heart was enlarged, (Fig. 2); the pericardial sac contained 30 cc. of

Fig. 2.—Heart: The heart was enlarged, ventricles dilated, musculature hypertrophied and myocardium flabby.

clear fluid which was increased in amount. The heart measured 14 cm. at the base and 12 cm. from apex to base and weighed 620 Gm. The myocardium was flabby. The right atrium was thickened. The right ventricle was also thickened and dilated, measuring 6 mm. The left ventricle was dilated, and the papillary muscles hypertrophied, in spite of the fact that the thickness of the left ventricle was only 13 mm. The heart was thus both enlarged and dilated. Grossly, on the endocardial surface there were small opaque flecks on the endocardium of both the right and left ventricles. The myocardium was flabby without demonstrating any particular abnormalities such as scars or softening. The liver was enlarged, weighing 1,850 Gm., and on section showed the picture of congestion. The spleen was also enlarged, 320 Gm., due to congestion. The kidneys were enlarged, each weighed 50 Gm. and showed nothing abnormal excepting congestion.

Microscopically the heart showed diffuse interstitial and replacement fibrosis which was still progressive. (Fig. 3) The liver showed severe congestion and central necrosis, which is responsible for the abnormal functional tests that were found. This is a case of chronic myocarditis not of the type caused by arteriosclerotic heart disease, but by either an inflammatory or degenerative process. One can consider the upper respiratory infection which the patient had just prior to the onset of his symptoms as the initiating factor. At least in acute myocarditis, upper respiratory infection is a very common predisposing factor. As Doctor Correll stated, this form of chronic myocarditis is often seen in alcoholics. There are many references in the literature to this form of heart disease occurring in younger individuals. This encompasses a wide group of apparently unrelated types such as "pernicious myocarditis," "fibrosis of the endocardium," "idiopathic cardiac hypertrophy," etc.

Clinical Diagnoses:

1. Recurrent pericardial effusion
2. Nutritional myocarditis

Anatomical Diagnoses:

1. Chronic myocarditis
2. Cardiac hypertrophy
3. Congestive failure

There have been other recent descriptions of this type of heart disease, and I am sure that Doctor Lustok can contribute to the story of chronic myocarditis.

Discussion

Dr. M. J. Lustok: Our original interest in myocarditis as an entity developed during an opportunity for clinical study of a specific type of myocarditis seen among the troops in the European Theatre who were infected with diphtheria. Subsequently, our interest here was stimulated by a pocket file of interesting clinical situations that Doctor Correll carries, among which was a rather large series of cases of congestive heart failure of unknown etiology. With encouragement by Doctor Lubitz, Doctor Chase and I studied these cases and found that some of the unexplained clinical syndromes were actually due to instances of myocarditis similar to the type described here. This patient was one of that original group. Since then, we have alerted ourselves and the resident staff to the discovery and observation of myocarditis. Medical experience has grown to accumulate a current series

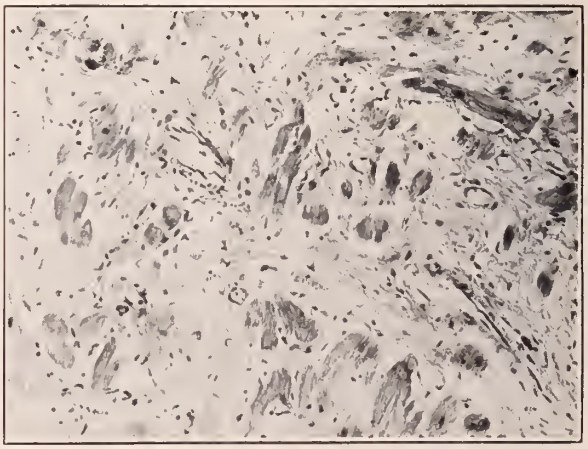

Fig. 3.—Heart, microscopic: Diffuse fibrosis in the interstices and replacing the myocardial fibers. Fibroblasts and lymphocytes indicate that the fibrosis was still active.

approximating 50 cases, of which about one-third have died and the diagnosis confirmed at autopsy.

Originally we were singularly concerned with the diagnosis. The diagnosis, we postulated, should be based upon an event such as was described here—a history of infection and/or alcoholic malnutrition and clinical syndromes presenting either nonspecific electrocardiographic changes or serious cardiac arrhythmia, evidences of diffuse globus cardiac enlargement with reduced muscular excursions and in severe cases, signs of total heart failure, for which no other obvious explanation was present, *i.e.*, no rheumatic fever, coronary disease, arteriosclerosis or hypertension. With improvement in diagnostic skill, the number of discovered cases in residence increased, and some cases were subsequently confirmed at autopsy. On the electrocardiographic observation alone, I recollect one patient here who was on the general medical service because of a very severe upper respiratory infection and on whom a routine electrocardiogram was taken and interpreted as showing changes suspicious of myocarditis. The man apparently recovered and was discharged before the report of the electrocardiogram reached the ward. He was re-admitted several months later in congestive heart failure.

Cases which were diagnosed clinically, and had since come to confirmation at autopsy, have substantiated the clinical diagnostic criteria. At the present time, we have two patients with acute myocarditis on the wards. Both are relatively young men and neither exhibits rheumatic, coronary, arteriosclerotic, or hypertensive backgrounds. Both are rather heavy drinkers and present deficiencies in dietary intake. Both were admitted to the hospital in total heart failure. We no longer consider this diagnosis a rarity.

The treatment of this condition is one of current interest. In our early experience we treated the total heart failure along the basic pattern for the treatment of this syndrome—bed rest, digitalis, salt restriction, and mercurial diuretics. It appeared from theoretical consideration, at least, that digitalis would be a drug not indicated and perhaps contraindicated in this type of heart failure, because it is an agent that would be expected to exhibit its pharmacologic action upon a tissue which was markedly altered, edematous, and acutely inflamed. We began to utilize the other available means of control of congestive failure and avoiding digitalis. Our recent and the current cases in residence have responded quite promptly to reduction of the hypervolemia and the edema by mercurial diuretics and salt restriction. Bed rest, highly nutritious diet, and high vitamin therapy were expected to supplement myocardial recovery. We have controlled and eliminated the congestive failure without employing digitalis. In these instances congestive failure did not recur after termination of bed rest, salt restriction, and mercurial diuresis. Some cases have been observed for many months, and they have apparently maintained an adequate cardiovascular balance. Highly nutritious diets and abundant vitamin supplement were maintained. Some of the individuals which we treated in this manner have again returned in congestive failure, but with history of reverting to alcoholism and the concomitant poor dietary intake. The acute onset of the relapse was almost universally anteceded by an upper respiratory infection. These cases, we feel, are recurrences, not remissions of myocarditis. In chronic congestive failure, which ensues, often multiple recurrences of the acute phase have induced extensive myocardial fibrosis, the use of digitalis cannot be, and perhaps should not be, avoided.

The clinical picture of myocarditis, to repeat again, is frequently implanted on a background of alcoholism and poor nutritional state, although we have seen some myocarditis in children and young adults where such a history is not present. Common etiologic states for heart disease are absent in the clinical evaluation. Antecedent upper respiratory infection and, not infrequently associated pneumonitis, is characteristic but not universal. The physical findings are those of poor muscular quality heart tones, often a mushy first mitral sound and a dull second mitral sound approximating each other in intensity, quality and duration, giving rise to tic-toc rhythm. The development of a systolic murmur, which is an indication perhaps of left ventricular dilatation, is not unusual. The electrocardiographic evidences are those of nonspecific T wave changes which may be generalized or very sharply localized over certain areas of the precordium. Arrhythmias are not uncommon.

Fluoroscopic observation reveals a globus nondescript, dilated heart with very poor muscular excursions. The patient not infrequently presents himself to the physician only when total heart failure has superimposed itself upon these earlier, relatively asymptomatic clinical features. Characteristically, in the first or second attack, the electrocardiograph changes, as well as the disruption in the quality of heart tones, are completely reversible. The cardiac silhouette again resumes its normal graceful contour with successful therapy. After multiple attacks, however, healing by fibrosis is so extensive and involves such wide areas of the myocardium, the situation that we are seeing today, that a chronic state of heart failure ensues, until ultimately the patient goes into intractable congestive failure and expires.

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However, since Dr. C. A. Good of our clinic is able to detect evidence of thymoma in 15 per cent of our patients and since thymomas do tend to invade surrounding structures, they are removed, provided the risk of operation is not considered great. We no longer recommend thymectomy in an effort to cause the myasthenic symptoms to abate.

Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

Dangers of Intrathecal Medication

Wilson and associates of Philadelphia, maintaining that injection of any foreign substance into the subarachnoid space produces an aseptic meningeal reaction characterized principally by pleocytosis and increased protein content, consider that use of this portal is illogical for most therapeutic agents and possibly unnecessary for all. The Swift–Ellis treatment, a formerly popular technic for introducing arsenic into the spinal canal in neurosyphilis, resulted in many cases of paraplegia, vesicle disturbances, and death from concomitant meningitis. Purulent aseptic meningitis has followed intraspinal injection of tetanus antiserum and intrathecal use of antimeningococcus serums and convalescent serums for poliomyelitis. Even spinal anesthesia or alcohol injections may be followed by neurologic disturbances though the nervous system is presumably free from disease. Many cases of paraplegia, cauda equina paralysis, radiculitis, arachnoiditis, and necrosis of the spinal cord have followed subarachnoid administration of sulfonamides. Several groups of observers have reported that intrathecal injection of large amounts of penicillin produce convulsions, coma, and death. The frequency of relapse in meningitis when penicillin is given intrathecally suggests that a reactive exudate encysts infection inaccessibly in the meninges and causes the reinfections. The toxic effects of intrathecally administered streptomycin are being increasingly recognized.

Some students of this subject have pointed out that spinal fluid reflects only what is going on in the adjacent neural tissues and that infection in the central nervous system is in the meninges and neural parenchyma, which have an adequate blood supply. Therapeutic substances diffuse slowly through the subarachnoid space and many regions of the nervous system are relatively inaccessible. It is in fact doubtful that an appreciable quantity of any medicament introduced intrathecally diffuses extensively through the subarachnoid pathways because the direction of cerebrospinal fluid flow is from the ventricles to the subarachnoid space. Perhaps benefit is obtained from such injections only after absorption into the blood stream has occurred. —HARRY BECKMAN, M.D.

POSTGRADUATE COURSES OFFERED IN MILWAUKEE ON MAY 3 AND 10

A postgraduate course on "X-Ray Interpretation of Diseases of the Chest" will be presented at Veterans Hospital, Wood on two Saturday mornings, May 3 and May 10. Sponsored by Marquette University School of Medicine and the Wisconsin chapters of the American College of Chest Physicians and the American Academy of General Practice, the courses are certified for six hours of formal teaching credit for members of the Academy of General Practice. Reservations may be made by sending the tuition fee of $10 to the Director of Postgraduate Education Programs, Marquette University School of Medicine, Milwaukee 3, Wisconsin.

The programs are as follows:

May 3—Dr. Mark Gary, Moderator

8:50 Registration
9:00 "Interpretation of Basal and Lobar Lung Shadows," Dr. H. H. Wright
10:00 "Interpretation of Triangular and Ring Shadows," Dr. S. A. Morton
11:00 "Significance of the Cardiac and Mediastinal Silhouettes," Dr. Mischa Lustok

May 10—Dr. Roger Hemphill

9:00 "Increased Translucency," Dr. L. H. Hirsh
10:00 "Interpretation of Round Lung Shadows," Dr. J. L. Marks
11:00 "Interpretation of Disseminated Nodular Lung Shadows," Dr. A. L. Banyai

THE MEDICAL FORUM

DRUGGISTS TAKE DISPENSING COMPLAINT TO COURT

BULLETIN

Madison, April 15.—Attorney General Vernon W. Thomson, acting on behalf of the State Board of Pharmacy, has filed a demurrer to the complaint of the Wisconsin Pharmaceutical Association against the state board.

THOMSON

The demurrer is in effect a request that the Dane County Circuit Court dismiss the complaint because it appears that the complaint "does not state facts sufficient to constitute a cause of action."

It was further pointed out that "there is a defect of parties defendant by reason of the omission of the physicians and their employees . . . in that the sole objective of the action is to settle the rights of these persons and others similarly situated with reference to the preparation, compounding, dispensing and delivery of dangerous drugs and that such persons are therefore necessary parties to the action."

It is believed that the court may hold a hearing on the demurrer before May 1.

SURVEY MAY BRING REVAMPING OF VA

Washington, D. C., March 11.—"A different kind of organization" will be created within the Veterans Administration following the completion of a management survey by private consultants, according to Vice Admiral Joel T. Boone, chief medical director of the VA.

The consultants have been studying all phases of VA operations since January, 1951, and their report will be made public in about 60 days.

Admiral Boone's comments were made during an American Legion Rehabilitation conference at which he was asked what had been done to carry out recommendations of a Congressional subcommittee for changes in the VA medical setup.

Over $600 000 has been spent on the study. The survey will be full and complete and recommend how the VA is to be "organized and operated."

Current Medical School Expansion is Greatest in Nation's History

Chicago, March 10.—A survey conducted by the New York Times shows that the greatest expansion program in the history of medical education is now under way in this country.

A survey of 80 medical colleges and 48 state commissioners of education shows that a medical college expansion costing $250,000,000 is currently in progress.

According to the survey, medical colleges will spend within the next few years. $50,000.000 for laboratories, $30.000.000 for classrooms, and $20,000 000 for dormitories. Another $100,000,000 is earmarked for research and special projects. In addition, the immediate cost for establishing new medical institutions will run about $50,000,000, making an over-all expansion program of a quarter of a billion dollars.

Seek to Stop Use of Doctor's Employees as Assistants in Dispensing

Madison, Mar. 15.—The Wisconsin Pharmaceutical Association has started a court action to force physicians to stop using their office employees as assistants in the dispensing of drugs to patients.

The suit was filed in the Dane County Circuit court against the Wisconsin State Board of Pharmacy for allegedly failing to enforce the provisions of the so-called "dangerous drug law."

The pharmaceutical association's suit charges that there is a "common, wide-spread and growing" violation of the dangerous drug law by "physicians and unqualified employees." It also states that "a substantial majority" of practicing physicians in Wisconsin "do not engage" in such acts.

The suit charges that physicians have improperly and illegally delegated to office employees such responsibilities as counting out, packaging, labeling and delivering drugs to patients, even though such actions are performed by direction of the physician.

When called by the press for comment, Mr. C. H. Crownhart, secretary of the State Medical Society, said the court action sounds like a "fence-me-in" proposition.

The amount of drugs sold out of doctors' offices is "insignificant compared with the total," he said. In most rural parts of the state, he explained, pharmacy service is not available to patients on a 24-hour basis and physicians dispense drugs to assure proper medical care.

He pointed out that, because of expense, not all pharmacists care to stock the numerous new or seldom used drugs a physician wishes to prescribe.

Concerning ethics, Mr. Crownhart said that the AMA code was never intended to mean that doctors should dispense at a loss. There is no question of the phy-

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Forum Feature

Unsanitary Homes Not Tolerated

NURSING HOMES FACE INSPECTION BEFORE LICENSURE

By VINCENT F. OTIS
Director, Hospital Division
State Board of Health

Madison, March 15.—More than 500 nursing homes have registered according to the 1951 law requiring the licensing, regulation and accreditation of Wisconsin nursing homes.

The Division of Hospital and Related Services of the Wisconsin State Board of Health is currently readying minimum standards for the operation of these homes in preparation for the issuance of licenses starting July 1, 1952. All homes are required to have a license following that date. By June 30, 1952, every home must be inspected by an employee of the Board of Health.

May Not License All Homes

The findings during these visits will determine whether the nursing home operator will be eligible for a license or a provisional license. According to the new law, a license may be granted for a specific maximum bed capacity to avoid overcrowding and the applicant for a license shall be fit and qualified.

It is anticipated that some denials of licenses will be necessary in some homes where existing conditions are such that little hope can be expected for even gradual improvement.

Many of the homes will probably receive a provisional license, which is good for one year only, during which time conditions may be corrected to meet the minimum standards established. The better operated homes will probably obtain an unconditional license and may wish to become accredited as a reward for their higher standards.

Define Nursing Home

A nursing home is defined, according to the 1951 law, as any building, structure, institution, agency or other place, whether proprietary, governmental or nongovernmental, for the reception and care or treatment not less than 72 hours in any week of three or more unrelated individuals, who by reason of aging, illness, blindness, disease or physical or mental infirmity desire any such services, and for which reception and care or treatment a charge is made.

The term "nursing home" includes, but not in limitation thereof, boarding and convalescent homes for the aged, infirm or chronically ill.

The law excludes homes owned and operated by county governmental units, since they are regulated by the State Department of Public Welfare.

With the assistance of an advisory committee, the State Board of Health is establishing minimum standards for the care, treatment, health, safety, welfare and comfort of patients and residents in the homes, and for the construction, general hygiene, maintenance, and operation of nursing and related homes which, in the light of advancing knowledge, will promote safe and adequate accommodations.

Advisory Committee

A 9-member advisory committee to the State Board of Health is functioning to advise and consult in the establishment and review of minimum standards and rules and regulations for the licensing and accreditation of nursing homes. Members of the advisory committee and their general field of interest are:

Margaret Healy, R.N. (Nursing) Milwaukee
Raymond S. Hirsch, M.D., (Medicine) Viroqua
Albert Incani (Nursing Home Operation) Eau Claire
E. H. Jorris, M.D., (State Board of Health) Madison
George Keith (State Public Welfare) Madison
Robert B. L. Murphy (Civic Interests) Madison
Mrs. Mollie Rahr (Social Services) Manitowoc
Margaret Schloemer, R.N., (Hospital Administration) Elkhorn
Theda L. Waterman (Civic Interests) Milwaukee

Of the homes thus far registered, 47% are under 10 beds; 29% under 20 beds; 11% under 30 beds; and only 13% over 30 beds. There are approximately 8,328 beds available with 7,223 occupied beds as of July 1, 1951.

Many of the better homes have long waiting lists, particularly the homes that admit bed ridden patients. The few vacancies in existence are probably in homes with lower standards or homes just recently opened for occupancy. There are vacancies in areas of the state which have an oversupply of nursing homes, but crowded conditions and waiting lists exist in areas with a shortage of these homes.

Regional meetings have been held in the cities of Milwaukee, Madison, La Crosse, Rice Lake, Antigo and Oshkosh for the purpose of informing the operators of the nursing homes about the requirements of the new law.

Under federal law, all old age assistance recipients living in nursing homes must, by July 1, 1953, live in a home licensed by the state to continue receiving federal aid.

Any standards to be developed for the care of the aged will have to recognize the urgent need for these facilities as well as the growing demand for expansion. Nevertheless, unsanitary, unsafe and crowded conditions will not be tolerated if they truly endanger the lives of residents in such facilities.

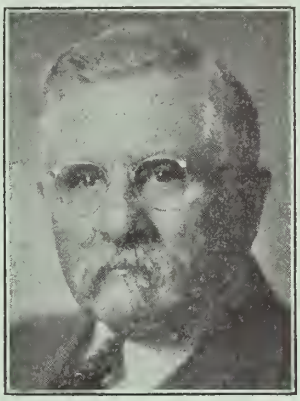
All Washington–Ozaukee Members Give $10 to Medical School Fund

Thiensville, Wis., March 15.—The Washington–Ozaukee County Medical Society recently took action to contribute $10 per member to the American Medical Education Foundation.

The donation will be acquired by assessment on each member of the two-county society.

The American Medical Education Foundation is an A.M.A. organization to obtain voluntary contributions for use in financial support of the nation's approved medical schools.

HONOR DR. FROST FOR GREAT WORK IN TB AND BACTERIA RESEARCH



DR. W. D. FROST

Madison, Mar. 15.—"To perpetuate the memory of Dr. Frost."

Colleagues and friends joined in this tribute as they announced to Dr. William D. Frost, Madison, veteran TB fighter, that one of the main buildings at Morningside Sanatorium would be named for him.

Dr. Frost was one of the founders of the sanatorium and for many years served on its board of directors. He was honored at a testimonial dinner as he retired as president of the sanatorium.

Dr. Frost is an emeritus professor of bacteriology at the University of Wisconsin where he served from 1895 to 1938.

In emphasizing Dr. Frost's accomplishments, Dr. William S. Middleton, dean of the university medical school, said that his work in defining the transmission of infectious mastitus bacteria in cattle to human beings was "one of the finest contributions to come from the University of Wisconsin."

Dr. Frost also performed "monumental research work" on bacteria in the soil. Dean Middleton said that because this work was not followed up in 1904, the discovery of pencillin was delayed perhaps a generation.

Many others, friends and colleagues alike, joined in tribute to the "integrity, ingenuity, stability, and tenacity of purpose with which he rendered a lifetime of service to his city and state in the fight against the Great White Plague."

DRUGGISTS TAKE . . .

(Continued from page 385)

sicians' right to dispense. If they charge more than the cost price of the drug, Mr. Crownhart said it was to cover dispensing costs, including those due to deterioration.

Mr. Crownhart explained to the press that physicians' office employees do not compound drugs. They package prepared drugs and deliver them to patients upon orders of the physician.

"If the pharmacy association's position is correct," Crownhart added, "the implications of the suit go far beyond the matter of dispensing in physicians' offices. Every hospital has a drug room, but not all have registered pharmacists. The same is true of convalescent homes. Similar situations exist in many industrial plants. It appears that the association would prevent nurses from giving drugs to patients on doctor's orders.

"Furthermore, if the interpretation of the law desired by the pharmacists is applied to the big city physician's office, it must be applied equally to rural areas without adequate pharmacy service and to hospitals, nursing homes, industrial health programs and various state or county institutions."

The pharmaceutical suit specifically names all five members of the state board of pharmacy as defendants. The association said that about a year ago it gave the board of pharmacy evidence of "some 18 alleged violations" of the drug act by physicians and their employees. No names or specific incidents are mentioned in the suit.

These violations are said to show that some physicians are "directing or permitting unqualified employees" to perform the following services:

1. **package and deliver dangerous drugs to members of the public in the absence of the physician and without a written prescription.**
2. **prepare dangerous drugs for delivery to members of the public and deliver the same, including the counting or measuring of such drugs, placing them in containers, and affixing labels with or without directions for use as required by law.**
3. **refill containers of dangerous drugs without a written prescription or order and without making an accurate record of such refilling or prescription as required by law.**
4. **dispense and deliver dangerous drugs without written prescription of a practitioner, contrary to law.**

Before acting upon these charges, the association says that the state board of pharmacy obtained an opinion from Attorney General Vernon Thomson, who is legal advisor for the board.

The attorney general's opinion concluded "that where a doctor has a stock of drugs on hand, and in the course of treating a patient he instructs his office girl to furnish the patient with certain named tablets which she proceeds to ob-

(Continued on page 392)

CLAIM BLANKS

A Wisconsin doctor is likely to handle more TIME claim blanks than any other company's. TIME, a leader in the accident and health insurance field, insures a large portion of the total number of persons carrying such insurance in Wisconsin.

Few doctors appreciate the great service given to their patients when these claim forms are handled promptly.

Any suggestions from you as to how our claim forms may be improved will certainly be appreciated.

* * *

The Time Insurance Company

818 WEST WISCONSIN AVENUE

Milwaukee 3, Wis.

HOW YOU GET YOUR MONEY'S WORTH FROM AMA DUES

By W. W. BAUER, M.D.
Director, Bureau of Health Education
American Medical Association

This is the second of two articles by Dr. Bauer on the AMA's services to its members. The first appeared in the March issue of the Medical Forum.

The Bureau of Medical Economic Research has combated another kind of quackery practiced by the distorters of statistics and the misusers of facts and has, in addition, contributed much constructive statistical research, establishing such new concepts as medical service areas supplanting the old county unit system, and pointing out that medical costs have risen less than general living costs and that medical efficiency is not measured by number of doctors but how much and how well doctors can serve their patients; these are but a few of the contributions of this Bureau. It has also established the growing importance of accidents in mortality and morbidity.

Hidden away in a corner, although a corner of sizable proportions now, is a little-known department, the Chemical Laboratory, upon which the scientific councils of the Association lean heavily in the evaluation of drugs and foods.

The library of the Association, with its periodical lending and clipping service and the book reviews and abstracts in the JOURNAL, is well known to most physicians. This in itself is a service for which commercial organizations collect far greater fees than the $25 which the doctor pays per year for the privilege of calling upon the resources provided by the A.M.A.

Another part of what you get for your $25 is the Washington Office which has maintained in the capital city a dignified, informative channel of contact with our national legislators which they have appreciated increasingly in the few years this office has existed. Much of the information about pending legislation affecting the public health and the practice of medicine would reach the medical profession too late or not at all if it were not for the Washington Office.

In every war situation the medical profession, despite adverse publicity, has always fulfilled its obligations to the nation. At the present time the Council on Emergency Medical Service is performing a patriotic duty in procurement of medical officers for the armed forces and at the same time maintaining adequate service to the civilian population and protecting the legitimate interests of doctors.

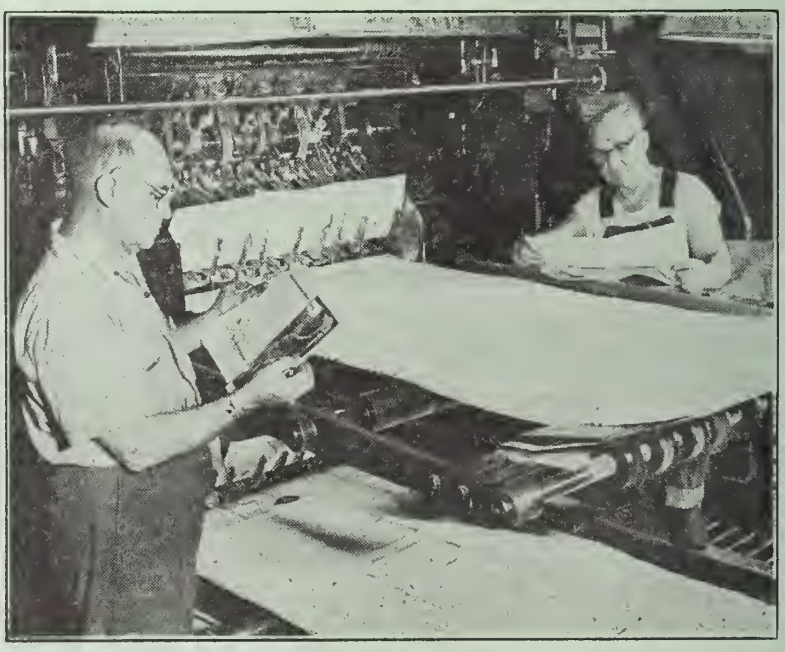
Public Relations Service

In the field of public relations everyone knows of the determined educational campaign conducted by the Association to ward off the threat of governmental control in medicine. Much less publicized are the public relations values of the continuing services rendered by the Association. Any and all of the activities already enumerated have inevitable repercussions of a favorable nature upon the public attitude toward the medical profession.

Health education is so closely related to public relations that the line of demarcation is often very hazy and only the close cooperation which exists between the Department of Public Relations and the Bureau of Health Education prevents duplication, over-lapping, and unwholesome competition. The Public Relations Department handles press and magazine relationships. Network and transcribed radio and television have been assigned to the Bureau of Health Education as well as convention coverage in this field for the Annual and Clinical Sessions.

The Public Relations Department sometimes handles radio and television in connection with the meetings held by various bureaus and councils such as the Annual Congress on Medical Education and Licensure, the Congress on Industrial Health, the meetings of the Rural Health Committee, etc.

The electrically transcribed health programs of the Association have a very definite accessory value in public relations, covering, as they do, 80 per cent of the nation's heavily populated areas with 11,000 annual broadcasts in which 300 to 600 of the country's 800 AM radio stations participate. So also do the occasional documentary network programs. The Question and Answer correspondence with lay readers



The Journal of the American Medical Association coming off the presses. In addition the AMA produces nine specialty journals, Today's Health, and thousands of pamphlets and reports.

extends direct personal service to 15,000 inquirers a year.

Committee work and advisory services extended by many departments to governmental agencies, voluntary health agencies, cooperating professional groups, educators, business men's and women's organizations, labor unions, and religious organizations all have a two-fold value: they give needed help which can come only from medical sources, and they make friends for the medical profession in ways difficult to measure, but no less real for all that.

The phase of committee, conference, and workshop service with which I am most familiar is that rendered by the Bureau of Health Education through our medical and educational consultants in school health work. Meeting with national and state level groups of doctors, educators, and public health workers and through national conferences on physicians and schools, these consultants offer

Have you used the AMA lending library?

a two-way channel of communication between doctors and educators, locating and smoothing points of friction, interpreting professional viewpoints, and cooperatively integrating interprofessional activities.

This work grew out of one of the earliest of the Association's liaison committees, the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association. Through these contacts it has been possible for me to serve twice on a year-book commission of the American Association of School Administrators, the first time in 1940–42, to originate the year-book, "Health in Schools," and the second time, this year and last, to revise that same book.

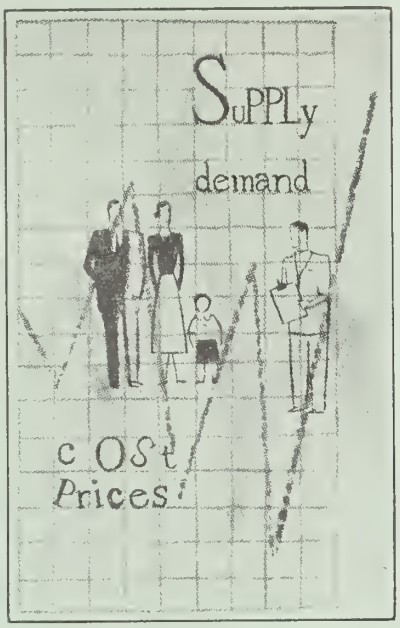
"Health in Schools" is among the most widely distributed and popular publications of the National Education Association. It contains nothing that is not in full accord with accepted medical principles.

Pamphlets such as "Suggested School Health Policies," "Health Appraisal of School Children" and others have been influential in establishing policies and procedures in relation to school health which improved the health of our children without impairing the family doctor relationships which we know to be fundamental to good medical care.

Unique in the publication field is TODAY'S HEALTH, the lay magazine sponsored by the medical profession. It has been copied by closely similar publications in England, Germany and Canada; an Australian edition has been proposed; it is the most widely quoted health magazine in the world. It offers a channel for health education and legitimate public relations which is not equaled anywhere because it reaches directly a conservatively estimated two million readers monthly, not counting uncounted and uncountable secondary readers who see it in libraries, in schools, and elsewhere.

This is what you get for your $25—but wait. I should say, this is what you might get for your $25 if you only would. How many times have you traveled to Chicago without visiting A.M.A. headquarters in which you have so heavy an investment of interest and of money?

How often have you referred a knotty problem in school health, in medical service, in medical economics or in the numerous scientific fields to the agency established by your representatives and financed by you? Have you supported by word of mouth the radio platter programs placed all over your state by your state medical society?



Facts on health needs and costs are supplied by the Bureau of Medical Economic Research.

Do you put TODAY'S HEALTH to work in your office, in schools, libraries and among your friends? On the basis of roughly twenty-five major activities at or closely related to A.M.A. headquarters they cost you each less than one dollar per year for direct services and for indirect benefits which can hardly be measured or evaluated.

If you don't get $25 worth for your membership check it may be due in part to the fact that you have never fully exercised your membership privileges.

IPS
PROFESSIONAL BUSINESS SERVICE
221 State Bank Building
La Crosse, Wisconsin
Consultants on Managerial and Tax Problems.
Practice limited to Medical and Dental Professions.
References furnished on request.

SOUTHERN EDITOR'S VIEWS APPEAL TO NORTHERN M. D.

"HEALTH PROGRAM MISLABELED"

One of the cleverest propaganda devices in the entire field of misrepresentation is that of applying an appealing label to something objectionable. Conquest may be concealed beneath the label of liberation. Expropriation of private property may be palmed off as land reform. Radicalism may be portrayed as liberalism, or vandalism and coercion as free trade unionism.

It is not surprising, therefore, that Oscar R. Ewing, head of the Federal Security Agency, recently attempted to switch the label on socialized medicine in testimony before a House expenditures subcommittee. Mr. Ewing told the committee that both he and President Truman were "unequivocally . . . opposed to socialized medicine."

Mr. Ewing appeared to oppose a bill creating a new health department to consolidate health services and eliminate duplication, particularly among the armed services and the Veterans Administration hospital services, in compliance with recommendations of the Hoover Report. He said, "The soundest and only feasible way to achieve departmental status for the health functions of the Public Health Service is by elevation of the Federal Security Agency, with all the functions for which it is now responsible, to the status of an executive department."

This would, of course, achieve Mr. Ewing's long-standing ambition to become a cabinet member in charge of all Government welfare, a move strongly opposed by those who feel that the Government has already ventured too far into the field of welfare. Mr. Ewing added he wished to emphasize "as unequivocally as I can, I am opposed to socialized medicine. I've never been for it. The President is not for it. The proposed health insurance program is not socialized medicine."

Politically, Mr. Ewing's definition represents a move in the direction of safer ground. Socialized medicine has become vastly unpopular, primarily due to the opposition of America's doctors, and it is obvious that if the program is to succeed, it must do so under some name other than socialized medicine. That is why it is called a health insurance program, although Mr. Ewing astutely omitted the word "compulsory" which should have preceded the phrase.

Perhaps a better look at the motives of the sponsors of socialized medicine can be obtained from another advocate of the plan, William Green, president of the American Federation of Labor. Mr. Green, in an article appearing recently in the American Federationist, went on at length to explain how Americans are suffering from the lack of medical care that they can't afford. He pictured doctors, generally, as callous individuals who must have cash on the line before ministering to the ill, and painted a glowing picture of how wonderful life would be under socialized medicine when good health for everybody would be achieved by magic. But the significant part of the article was contained in one short paragraph near the end:

DR. V. E. EKBLAD

Dr. Victor E. Ekblad, Superior, keeps his eye on the medical news wherever he goes. As a result, he sent the Society a clipping from the Savannah (Georgia) News-Press indicating that southern gentlemen (especially editors) don't use kid gloves when they punch at Oscar Ewing's health schemes. The editorial is reprinted at the left.

"And under national health insurance our unions can negotiate through collective bargaining to have management pay part or all of your premium. Unions could maintain their own plans of providing medical services which would be paid for out of the insurance fund."

This seems to answer one of the questions surrounding socialized medicine namely: "Where is the money coming from? It will come from business while organized labor, even though the chances for putting through the scheme are virtually nil, already envisions a giant "free ride" for Mr. Green and his supporters.

And what about the statement that the unions could maintain their own plans for providing medical services to be paid for by the Government. How can this be reconciled with the promises of the advocates of socialized medicine that both doctors and patients will be free of outside interference in their relationships? But, according to Mr. Green, the unions would have their own plans for providing service—although so far as we know there are no medical experts or doctors in the unions, and we fail to see how such ambition can be considered a legitimate function of a collective bargaining agency. Mr. Green, unwittingly, has provided a couple of additional excellent reasons why socialized medicine could never be tolerated by a free and democratic people.

DON'T MISS "MEDICINE U.S.A."

A new health education radio show sponsored by the AMA in cooperation with county medical societies and NBC.

6:30 p.m., SATURDAY, MAY 3

Broadcast by these Wisconsin radio stations:

WIBA, Madison
WEBC, Duluth–Superior
WKBH, La Crosse
WTMJ, Milwaukee

TELL YOUR PATIENTS TO LISTEN

COUNCIL COMMITTEE MEMBERS NAMED FOR 1952-53

Madison, March 15.—Dr. R. G. Arveson, Frederic, chairman of the Council of the State Medical Society has designated the following physicians as members of Council committees for 1952:

Advertising
Harry Beckman, M.D., Milwaukee
A. L. Tatum, M.D., Madison
N. A. Hill, M.D., Madison

Audit and Budget
E. M. Dessloch, M.D., Prairie du Chien, chairman
A. J. McCarey, M.D., Green Bay
J. M. Bell, M.D., Marinette
N. J. Wegmann, M.D., Milwaukee
J. C. Fox, M.D., La Crosse

Blood Bank Committee
W. D. Stovall, M.D., Madison
T. J. Greenwalt, M.D., Milwaukee
C. N. Neupert, M.D., Madison

Civil Defense Committee
M. J. Musser, M.D., Madison, chairman
E. P. Ludwig, M.D., Wausau
K. E. Lemmer, M.D., Madison
J. S. Wier, M.D., Fond du Lac
E. A. Bachhuber, M.D., Milwaukee

Military Medical Service
F. L. Weston, M.D., Madison, chairman
M. J. Musser, M.D., Madison
J. M. Sullivan, M.D., Milwaukee
M. H. Steen, M.D., Oshkosh
O. G. Moland, M.D., Augusta

Editorial Board
H. Kent Tenney, M.D., Madison, chairman
D. W. Ovitt, M.D., Milwaukee
Elwood Mason, M.D., Milwaukee
Frank Weeks, M.D., Ashland
G. E. Forkin, M.D., Menasha

Historical Committee
H. Kent Tenney, M.D., Madison, chairman
E. M. Dessloch, M. D., Prairie du Chien
N. J. Wegmann, M.D., Milwaukee
P. R. Minahan, M.D., Green Bay
E. E. Kidder, M.D., Stevens Point

Polio Consultants, Committee on
H. W. Wirka, M.D., Madison, chairman
R. S. Baldwin, M.D., Marshfield
R. F. Poser, M.D., Columbus
Marvin Steen, M.D., Oshkosh
Kenneth McDonough, M.D., Madison

R. G. ARVESON, M.D.
Council Chairman

School Health, Committee on
F. J. Mellencamp, M.D., Milwaukee, chairman
W. R. Manz, M.D., Eau Claire
A. C. Edwards, M.D., Racine
E. B. Pfefferkorn, M.D., Oshkosh
Amy Louise Hunter, M.D., Madison

Venereal Disease
Stephen Epstein, M.D., Marshfield, chairman
J. M. King, M.D., Milwaukee
P. C. Gatterdam, M.D., La Crosse
O. A. Stiennon, M.D., Green Bay
G. A. Cooper, M.D., Madison

Veterans Medical Service, Operating Committee
J. S. Supernaw, M.D., Madison, chairman, 1956
W. C. Finn, M.D., Fond du Lac, 1955
Maurice Hardgrove, M.D., Milwaukee, 1954
W. A. Fischer, M.D., Frederic, 1957
J. L. Moffett, M.D., Platteville, 1953

The Interim Committee of the State Medical Society includes the following (year term expires is indicated):

J. M. Bell, M.D., Marinette, 1953
J. C. Fox, M.D., La Crosse, 1955
R. E. Galasinski, M.D, Milwaukee, 1954

Ex-officio members of the Interim Committee include the chairman of the Council, Dr Arveson; Dr. S. E. Gavin, chairman emeritus; Dr. A. H. Heidner, president, and Dr. J. C. Griffith, president-elect.

The Commission on Prepaid Plans includes the following members with the dates indicating the expiration date of their terms:

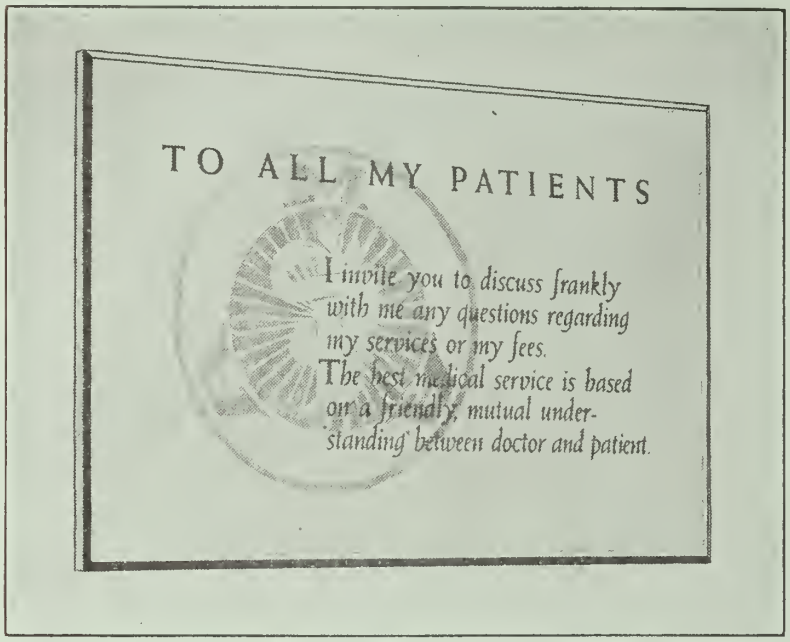
E. M. Dessloch, M.D., Prairie du Chien, 1955, chairman
Robert Krohn, M.D., Black River Falls, 1953, vice-chairman
N. A. Hill, M.D., Madison, 1955, treasurer
J. T. Sprague, M.D., Madison, 1953, assistant treasurer
T. D. Elbe, M.D., Thiensville, 1953
Charles Fidler, M.D., Milwaukee, 1953
H. E. Kasten, M.D., Beloit, 1953
J. W. Truitt, M.D., Milwaukee, 1953
R. E. Garrison, M.D., Wisconsin Rapids, 1954
K. H. Doege, M.D., Marshfield, 1954
Milton Finn, M.D., Superior, 1954
J. S. Supernaw, M.D., Madison, 1954
H. A. Aageson, M.D., Oconto, 1954
R. N. Moore, M.D., Frederic, 1954
C. G. Reznichek, M.D., Madison, 1954
W. C. Stewart, M.D., Kenosha, 1955
Richard Foregger, M.D., Milwaukee, 1955
H. B. Christianson, M.D., Superior
G. W. Carlson, M.D., Appleton, 1955
P. B. Mason, M.D., Sheboygan, 1955
Ex officio: President

Legion Health Survey Nears Completion

Washington, D. C., March 11.—The American Legion health resources survey should be completed by July of this year, according to officials of the Legion.

Edward McGrail of the Legion's rehabilitation service commented that "no one in national headquarters has any preconceived ideas" on the final survey.

The Legion hopes, however, that it will indicate places where Veterans Administration might build new hospitals.



PLAQUE ORDERS EN MASSE—Many county medical societies around the country have purchased quantities of the new A.M.A. public relations plaque for their members. Strong local support of the program for mutual understanding between patient and doctor will strengthen American medicine's position in the community and in the nation as a whole. Plaques may be purchased for one dollar each from your State Medical Society Office in Madison.

DRUGGISTS TAKE . . .

(Continued from page 387)

tain from the container and measure out for the patient, delivering the same to the patient, there is no violation" of the dangerous drug law, although the doctor may be liable for his own negligence or the negligence of his employee in such case.

Claim Opinion is in Error

The pharmacy association contends that the attorney general's opinion is in error. It alleges that his interpretation of the law is a "discrimination against pharmacists and their employees" because they do not have the same privilege to delegate dispensing responsibilities.

It further alleges that:

1. the opinion "denies free choice of pharmaceutical service to the public, and particularly to physicians' patients, to the detriment of the pharmacy profession and the public.
2. the number and names of new drugs is so confusing that the public health is endangered when "unskilled persons" dispense drugs without the opportunity for a second professional check on the accuracy of the designation and prescription of the dangerous drug.
3. pharmaceutical service by registered pharmacists is available within a 10-mile radius to 99% of the practicing physicians in Wisconsin and to 95% of Wisconsin communities having resident medical service.

The suit stresses the contention that the attorney general's opinion "amounts to an unjustified and unwarranted interpretation" of the law contrary to the interests of pharmacy and the public health, welfare and safety.

Film Review Booklet Available on Request

Chicago, March 15.—A booklet containing 90 reviews of medical and health films has just been released by the A.M.A. Committee on Medical Motion Pictures.

This 1951 supplement on medical movies is available upon request to the State Medical Society of Wisconsin, 704 East Gorham Street, Madison, Wisconsin.

Society Endorses Film on Overweight for Statewide Showing

Medical Society to Aid in Publicity

Madison, March 15.—The Council of the State Medical Society of Wisconsin has endorsed the showing of "Cheers for Chubby," a film on overweight, for showing in Wisconsin theaters.

As a result of the Council's action, all theater managers will receive a letter over the signature of the Society president, urging him to bill "Cheers for Chubby" in his theater.

This film dealing with weight control, will be shown throughout Wisconsin during the months of April and May, and presents a physician's advice in animated cartoon form.

this sword means Cancer SERVICE

Six hundred thousand patients are under treatment for cancer today.

For many of them the American Cancer Society helps provide medical services, dressings, transportation, articles of comfort and necessity, relief from pain.

The volunteers who work under the sign of the cancer sword need your support. Cancer Strikes One in Five. Your Dollars Strike Back.

Mail Your Gift to "Cancer" Care of Your Local Postoffice

AMERICAN CANCER SOCIETY

As It Looks to Your State Board of Health

(These timely discussions of health problems are prepared by staff members as a special service to Wisconsin's physicians.)

Nursing Homes and Medical Standards

One of the results of the increase in the number of older people in our population and the associated increase in chronic illness has been a sudden growth in the field of nursing homes. This type of institution has mushroomed all over the state. While they have developed to meet a definite need, they have not been an unmixed blessing. Some of them are good and some are not so good.

Contrary to common belief, they are not all run by registered nurses. True, there are a few with a registered nurse in charge, but some are owned and maintained by practical nurses who may or may not have had training.

The type and quality of care given varies with each home. Some do not attempt to give any nursing care at all, but, rather, are equipped to give only custodial service. At the other extreme are those that are well staffed and well equipped and could be considered an auxiliary of the hospital. Because of the wide variance in the type of service and quality of care, some local municipalities have had a licensing program, thus maintaining a routine inspection of these homes. This has been very satisfactory and has, in part, led to the adoption of a statewide program of licensing, which will become effective in Wisconsin on July 1. While licensing is not the whole answer, it does provide certain minimum safeguards and, when accompanied by an educational program, can do much to improve the quality of care given in the various homes.

One of the urgent needs in the various homes, particularly where bedridden patients are cared for, is better medical *supervision*. A few of the large fraternal or denominational homes have well-run infirmaries with a visiting physician in charge. This is not true of the small commercial homes where all too often the medical supervision is quite inadequate.

A physician has the right to expect, when he has recommended nursing home placement for his patient, that the patient will receive adequate care at a reasonable price. This immediately brings up the questions of what is adequate care and what is a reasonable price. Generally speaking, adequate care can be taken to mean that the patient will be kept clean, will be given the medication and treatment recommended by the physician, and will have a suitable and adequate diet. Such care would include supervision of the patient to be sure that there is proper elimination.

To date, few homes provide any rehabilitation service. Some have services such as are available in the Curative Workshop of Milwaukee, but these homes are limited due to their shortage of staff. A limited program of recreation is about the extent of activities in most homes.

The type of medication and treatment that can be handled in a given home will naturally be determined by the personnel. Very few homes attempt to give oxygen therapy, venus injections, or deep hypodermics. By and large, the care is usually that which can be given by practical nurses and nurses' aids. There are, of course, exceptions.

What constitutes a reasonable price is a much debated question. In these days of soaring costs of food and wages, it is extremely difficult to determine what is a fair price. A little exploring by the physician or family will indicate what are the usual prices in a given vicinity. In ascertaining prices it is always well to determine what is included in the quoted price, as often there is an extra charge for many items. In helping the family to evaluate the cost, the physician can help to safeguard them from exploitation.

In the past, the question of safety was one to be considered. Now, with state licensing, it will be less necessary for the physician or family to consider such things as fire hazards or sanitation.

However much we may attempt to control the type of environment and care, we will not be completely successful until we have devised some way of determining the type of person who would be qualified to run a nursing home. Fire and sanitary inspections are good, but they do not insure kindness and consideration from the operator.—THEDA WATERMAN, *Chairman, Advisory Committee on Nursing Homes.*

ANNOUNCEMENTS FROM THE AMERICAN COLLEGE OF CHEST PHYSICIANS

The Board of Examiners of the American College of Chest Physicians recently announced that the next oral and written examinations for Fellowship will be held in Chicago on June 5. Candidates for Fellowship in the College who wish to take the examinations should contact the Executive Secretary, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois.

The eighteenth annual meeting of the College has been scheduled for June 5 through 8 at the Congress Hotel in Chicago. A scientific program covering all recent developments in the treatment of heart and lung disease is being arranged.

LIBRARY OF THE
COLLEGE OF PHYSICIANS

Facts about

Blue Shield of Wisconsin

an agency of the State Medical Society of Wisconsin

Prepared by the Directing Board of Blue Shield of Wisconsin, an Agency of the State Medical Society of Wisconsin, E. M. Dessloch, Prairie du Chien, Chairman.

New Blue Shield Program

Since April 1, the new Blue Shield (Wisconsin Physicians Service) contract has been ready. Only the group contract has been offered for purchase to this date. By June 1 it is expected that non-group and conversion contracts will also be ready. The program involves two income levels with an appropriate revised schedule for each. It embraces surgery in the hospital, home or office, medical care in hospitalized cases, radiology associated with surgery and anesthesia associated with surgery.

This month the Blue Shield page will outline only the general format of the new program. In subsequet issues, the new contracts will be explained in detail and pertinent questions and answers presented.

At any time physicians have any questions relative to Wisconsin Physicians Service—old or new contracts—please write or call Wisconsin Physicians Service, 704 East Gorham Street, Madison 3, Phone 6–3101.

Question: When will patients have the new contract?

Answer: Few, if any, groups will be sold the new WPS coverage during April. Starting July 1, however, all contracts sold will be the new WPS program. Also by July 1, all non-group and conversion contracts sold must be the new program.

Question: How long will it be before all persons having WPS will have the new contracts?

Answer: It will take until July 1, 1953, before all old contracts have been changed over to the new contracts. Three thousand groups, involving about 80,000 contracts, must be changed over. Outstanding contracts of WPS will be honored until then. That is, the benefits for persons holding the old contracts will be accepted according to the terms of those contracts and by participating physicians as "full payment." After July 1, 1953, the old plan will no longer be honored.

Question: How will the physician know whether a Blue Shield subscriber holds the new or old contract?

Answer: The patient will have an Identification Card showing that he has the "A" or "B" plan. Since only the new program offers "A" or "B" income levels, the physician will know that the patient has the current program.

Question: How will the physician know what coverages the patient has under the new contract?

Answer: All new contracts offered by WPS will carry a box on the face of the contract showing which of the five coverages—surgical, maternity, medical, anesthesia, radiology—have been purchased by the holder. The boxes marked by a small blue shield will indicate coverages purchased. Coverages not purchased by the holder will be marked by the word "NONE" in the applicable box. Usually, however, the physician will not see the contract. He will rely on the patient's Identification Card to show these coverages. The front of the card will carry certain numbers in a box labeled "type of coverage." A key on the reverse of the card will explain the coverage.

Question: What is being done to explain the new program to physicians?

Answer: On April 1, a series of letters started going to all physicians. The first announced the pattern to be followed in placing the new contracts into effect. It was accompanied by a specimen contract, a schedule of benefits, and the specifications applicable to the new plan. On April 15, all physicians were contacted again to enroll as participating physicians in the Society's prepaid programs. Shortly each physician will receive a letter with a copy of the first public advertisement of the new plan. This page will carry questions and answers every month. Bulletins from the WPS office will be forthcoming periodically. Mr. Byron Ostby, now field secretary for the State Medical Society, will be contacting physicians personally to discuss WPS questions. Plans are under way to hold a series of conferences for physicians' employees (business managers and secretarial help) to acquaint them with administrative procedures of the new plan. A "Physician's Manual" will also be prepared to assist in this phase of WPS operation.

Question: How is the public being informed?

Answer: Advertisements will appear in every Wisconsin daily and weekly newspaper. Letters with copies of these ads will go to employers of groups having the old WPS contract, and to nearly 2,000 opinion leaders. Ads, news stories and pamphlets will help announce the plan.

. . . . THE PRESIDENT'S PAGE . . . .

Doctors in Politics

PHYSICIANS have long been criticized and reprimanded for their lack of participation in public affairs. It has been said that their interests were confined too closely to their own scientific and professional affairs.

In recent years, however, the public has become quite aware of the efforts of physicians everywhere to influence good citizenship. True, physicians' interests in "politics" caused little comment until the doctors aroused in themselves and the public an appreciation of the threat of compulsory health insurance. Physicians were quick to realize that this movement involved not only their individual welfare but jeopardized the entire system of American medicine and government. They know that the public will suffer far more than the physicians under a centralized medical service directed from Washington. They know that government control of medical care is deadly to the American philosophy in business, politics and everyday living. It is part of the socialism that has come to every country which adopted government medicine.

The fight to preserve personal freedom and incentive has brought medical men into politics. Our interest has gone far beyond the narrow sphere of government medicine. We know that government has a place in providing basic needs for those who cannot provide for themselves. But far more important is government's responsibility to insure the opportunity for the vast majority of people who, given that opportunity, can provide for themselves with enough left over to care for the rest. Freedom to get ahead and the right to be rewarded for personal effort, ability and industry are the greatest privileges of American citizenship. It is this philosophy which has made our country the envy of the world.

Because of our success in alerting America to the dangers of government control, some of the critics who formerly bemoaned our political lethargy now attempt to ridicule our efforts. We are told that medicine is losing the respect of the public.

Be not dismayed by such idle talk. No good citizen should or will fail to respect any other good citizen who is fighting for principles in which he believes and which he knows are right.

All doctors do not favor the same candidates for political office and no one expects them to do so. But I am sure most would agree in principle that we must improve the handling of our affairs of government or none of our progress—medical, economic or social—will be worth very much.

Yes, doctors are in politics. As long as they stay there I have hope that democracy will endure.

Albino T. Heidrich M.D.

Minutes of the Council Meeting, Madison February 23-24, 1952

1. Call to Order

The Council was called to order by Chairman Arveson at 2:00 p. m., Saturday, February 23, 1952, in the office of the State Medical Society, Madison.

2. Roll Call

Councilors present were Doctors Tenney, Kasten, Dessloch, Heidner, McCarey, Fox, Bell, Kidder, Arveson, Galasinski (Saturday afternoon), and Bernhart.

Also present were President-Elect Griffith; Drs. S. E. Gavin and W. D. Stovall, Delegates to the American Medical Association; Dr. J. S. Supernaw, chairman of the Veterans Agency; Dr. R. E. Fitzgerald, chairman of the Committee on Grievances; and Dr. C. N. Neupert, state health officer.

Others present were Secretary Crownhart; Assistant Secretary Ragatz; Mr. T. J. Doran, claims director; Mr. R. B. Murphy, legal counsel; Mr. R. J. Hoops, comptroller (Saturday); Miss Leona Kellerman and Miss Joan Pyre.

3. Report of Committee on Audit and Budget

The following report of the Committee on Audit and Budget had been presented to the councilors and officers and invited guests:

a. *Meetings of the Audit and Budget Committee*—It has been determined that the committee will meet quarterly in the future so as to review not only some special or current activity of the Society, but so that distribution of its work need not be as concentrated as it has been in the past. On the basis of time available to the committee, it has deferred until later meetings its audit of expenditures in 1950–51.

Beginning in January 1953, a certified public accountant will conduct the audit with a report to the Audit and Budget Committee for review.

b. *The Budget as a Guide*—The committee desires that emphasis be made of the fact that the budget, as recommended, operates as an administrative guide, and that it has been the practice of the secretary's office to underexpend the budget, as a whole, although individual items are sometimes moderately overexpended. If the secretary foresees during the course of the year that a budget authorization may prove to be substantially insufficient, the problem is reviewed with the Audit and Budget Committee and recommendations made to the Council.

c. *Financial Status of the Society*—In connection with the above comment, it is important that councilors and officers understand that in 1951 the authorized budget was underexpended an estimated $12,000. In 1950, the budget was underexpended approximately $11,000. For reference of councilors and officers, the Audit and Budget Committee recommends that the treasurer's report, containing a statement of assets, liabilities, and surpluses, be noted.

d. *Comments on Budget*—In connection with the information made available on the Society's activities, the Audit and Budget Committee recommends to the staff that each issue of the *Wisconsin Medical Journal* contain a schedule of the radio stations broadcasting the March of Medicine and the day and time of that broadcast. In addition, the Audit and Budget Committee, at the suggestion of Doctor McCarey, recommends that consideration be given to the distribution of the open panel to labor unions in the future.

4. Budget for 1952

The budget, as reviewed item by item and approved by the Council for the year 1952, follows:

1952 BUDGET

Account	*Budget Item*	*Appropriation*
53	CENTRAL OFFICE NORMAL OPERATING EXPENSE (All salaries, employee travel, employment taxes, and group insurance are included in the Payroll Account 59.03–59.06 inclusive)	
531	*President's Travel and Reimbursement*—For more than 10 years, this amount has been appropriated to the president and avoids the necessity of his vouchering the costs of his attendance at many meetings in behalf of the Society. Both the president and president-elect are notified of all committee meetings and expected to attend many of them, in addition to meetings of county societies and the like. The president is chairman of the Council's Interim Committee which meets monthly. Nationally, the same problem exists in the American Medical Association and was recognized by action of the House of Delegates in December, 1951, instructing provision of a liberal per diem allowance to this officer. ----------	$750
532	*Council, Officers, Delegates and Committee Meeting Expense*—This account carries the meeting expense of the committees of the Society, meetings of the Council, and the monthly meetings of its Interim Committee, the cost of sending three Wisconsin delegates to the AMA, together with travel expense of other physicians who officially represent the Society at such functions as the Rural Health Conference and similar meetings. The two 1951 national meetings of the AMA were on either coast. In	

Account	Budget Item	Appropriation
	1952, they will be in Chicago and Denver, with 1953 scheduled for New York and St. Louis, and 1954 for Miami and San Francisco. It will be noted that the appropriation in 1951 was only about two-thirds of the amount actually expended. This arises in part out of numerous meetings held in connection with the revision of the prepayment schedules and the structure of the prepayment plans, together with other increased activities among certain of the Society's committees. However, with the prepayment problem solved for the moment, it is not anticipated that 1952 will require a greatly increased appropriation. ___	$12,000
533	*Association and Dues Expense, State and National Organizations*—This represents a separate budgetary item for the first time. Previously, this expense has been paid out of the preceding account. The Society holds membership in, or supports, the following organizations, including membership for the secretary in clubs in both Madison and Milwaukee, these facilities being frequently used for smaller meetings and overnight accommodations for committee members.	
	North Central Conference (State Medical Associations of Wisconsin, Minnesota, the two Dakotas, Nebraska, and Iowa) _____ $100	
	National Society for Medical Research—animal experimentation _____ 50	
	Wisconsin Public Health Council _____ 100	
	Conference of Officials of State and County Medical Societies 50	
	Better Business Bureau of Milwaukee _____ 50	
	Associated State Postgraduate Committee _____ 25	
	World Medical Association ___ 10	
	Club membership, American and state hospital associations, State Chamber of Commerce, etc., approximately _____ 265	650
534	*Resource and Informational Material*—Various pamphlets and other publications are purchased and supplied to officers, councilors, and various members of committees, relating to a specific activity or responsibility. This is a varying procedure, depending upon new material issued and the need. _____	750
535	*Woman's Auxiliary to the State Medical Society*—For many years, in addition to assisting the Auxiliary in the program of the Annual Meeting ($500 annually), a nominal appropriation has been provided to reimburse stenographic, mailing, and other expense. Because of intensified efforts involved in the problem of health insurance, the Auxiliary has been called on for increased activity, both by its membership and other women's organizations. In 1951, it was felt that a reasonable sum should be provided the president and president-elect for their travel expenses. In this connection, note that the request of the Auxiliary for secretarial assistance is separately treated in the payroll budget. This appropriation also covers the expense of printing and mailing the quarterly bulletin of the Auxiliary.	$1,450
536	*Accounting and Insurance*—As reported to the Society in 1951, the certified public accountants were authorized to modernize the Society's bookkeeping methods which were first established in the 1920's and have since been continued in that mechanism. With the Society's increased dues account, the various classifications of memberships now existent, the substantial operations in the field of teaching clinics and the Annual Meeting, the collection of dues of the AMA, the operation of the building, and other matters, the prior system was antiquated and unsatisfactory for proper controls. The new system is more complicated and requires more assistance than has previously been available. This account also includes cost of compensation insurance, the bond on employees, and provides an amount estimated as necessary to provide the Society with a report of a certified public accountant beginning with operations in 1952. This report should greatly simplify in the future the presentation of details reviewed by the Auditing Committee. _____	2,800
537	*Rent*—In November, 1950, a Madison realtor was employed to evaluate the building for the purpose of determining a reasonable rent to be assigned the State Medical Society operating account and the several agencies involved. This computation was used by the accounting office for the purpose of the rental assigned the Veterans Agency and was based on actual physical space used, together with allocations for telephone line charges, switchboard operator's salary, maintenance, and mail service. In 1950, the total anticipated for the year was $13,763.88 against an actual total experienced of $16,672.44. Part of this is accountable by many items being slightly underestimated, the major items consisting of depreciation (not a cash disbursement) underestimated $300, interest being calculated on a $68,000 investment instead of $71,500, details of mail, salary, and other items being necessarily increased during the year because of changed circumstances. The fact of the matter is that rent will have to be reassessed annually, based upon the prior year's experience so that actual experience can only be anticipated and not calculated with certainty.	

Account	Budget Item	Appropriation

During the late fall of 1951 and the early months of 1952, substantial space reallocations were made with the space assigned the Veterans Agency being reduced, the space assigned WPS increased, and more utilization made of available space. Therefore, based on studies made by the accounting department, the secretary suggests that the total 1952 rental, with allocations based on the accounting department study, be $16,672.44 plus 5 per cent for adjustments. Based on this study, monthly rental would be rounded off to the nearest dollar.

	1951	*1952*
State Medical Society	$500.75	$650.00
Veterans Agency	241.50	211.00
Wisconsin Physicians Service	304.75	567.00
Wisconsin Medical Journal	100.00	32.00

$7,800

538 *Telephone and Telegraph*—Line cost is paid from the building funds so that each department shares the cost of the lines and the switchboard according to the number of extensions on the various desks. This appropriation carries the cost of long-distance calls and telegrams. It might be noted that many calls come collect. While substantially oxerexpended in 1951, it is believed that a moderate increase for 1952 will be sufficient. ---------- 2,000

539 *Office Supplies*—It is not possible to reduce this appropriation which carries the cost of mimeograph paper, typewriter ribbons, stencils, and miscellaneous office supplies, the cost of which has increased substantially in recent years. ---------- 3,300

5310 *Postage and Printing*—This account carries the cost of printing membership certificates, membership cards, letterheads, mailing expense, and other items. It does not include cost of mailing the Medical Journal which is paid through the Journal account itself. Postage rates were increased on some classes of mail January 1, and there appears to be no possible way of reducing this expenditure. The budget in 1951 was actually $4,000, but the item carried the cost of printing the quarterly bulletin of the Auxiliary which has been transferred to the Auxiliary appropriation so as to clearly state the financial support to the Auxiliary. ---------- 3,000

5311 *Upkeep and Fixtures*—This account is chiefly one of maintenance. For example, the Addressograph handles 200,000 and sometimes considerably more mailings each year. In addition, the Robotyper, the mimeograph machine, typewriters, adding machines, and other office equipment must be maintained. The account also carries the cost of maintaining the Addressograph plates of which there are approximately 5,000 in current use, 3,600 for membership distribution, including the Wisconsin Medical Journal, Addressograph plates for separate runs to councilors, officers, High Lights letters, and others so that manual addressing time will not be necessary on these letters. There are approximately 1,400 plates in connection with Auxiliary mailings. The frame and plate cost about 6 cents each. Each individual address plate involves about 3 cents. It will interest the councilors and officers that approximately 1,500 addresses or damaged plates are changed annually.-- $1,000

5312 *New Equipment*—One or two new typewriters are needed annually, and obsolete and worn-out equipment must be constantly replaced. Some four or five years ago the membership card, which had been carried in a drawer file, involved so much handling as new membership classifications were created and AMA dues were imposed, that it was necessary to place them on wheels. These wheels have been transferred to the vault when not in use for fire protection. With the substantial increase in membership activity, the need of coding cards to show enrollment in the Provident Insurance program, special membership classifications, and other matters, these cards can no longer be properly maintained. Therefore, the secretary requests a one-year appropriation sufficient to provide a Cardex system, commonly used among membership organizations for the maintenance of these records. It should be noted also that the amount estimated as the 1951 total expenditure includes some funds committed for equipment in that year, on which delivery has been delayed until 1952 because of steel shortages. -------- 3,000

5318 *Legal*—Prior to developments of the last four or five years, it was possible to carry normal legal expense in the neighborhood of $2,000 annually, but this provides no leeway for the unanticipated problems of each year. Our attorneys are frequently contacted directly by doctors and others for advice, and these requests are always cleared with the office before being fulfilled. However, when such requests are made by various state groups, they cannot be ignored. In addition, the attorneys advise the individual officers relative to their activities in behalf of the Society, attend all meetings of the Council and certain of the major committees and the like. Many of these are treated without billing inasmuch as the appropriation amounts in part to a type of retainer. ---------- 3,000

5319 *General Bulletins to Members*—The experience of each year indicates the requirements of at least three,

Account	Budget Item	Appropriation
	and sometimes four, special bulletins to members in respect to some unusual problem such as that distributed in 1951 relating to the views of the Wisconsin Pharmaceutical Association. The account carries the biannual reports of the delegates to the AMA. It is for printing only and does not include postage.	$600
5320	*Blue Book Issue, Special Appropriation*—The special issue of the Journal in January supplements the permanent Blue Book issued in 1949. This appropriation pays for the cost of special articles, over-the-usual printing expenses, and the like. It has been in the amount of $750 for some years, and a moderate increase is indicated.	900
5325	*Miscellaneous*—This is an overflow account for items which the staff does not anticipate or the assignment of which to any of the preceding accounts is not logical.	1,200
54	PUBLIC HEALTH INFORMATION, SPECIAL ACTIVITY	
541	*Today's Health*—This publication is sent by the Society to elected public officials and others who have special interest in public health matters. The circulation amounts to approximately 270, and the expressions of appreciation are obviously sincere. Consideration should be given to the expansion of circulation to several times the current number.	400
542	*Lay Publications*—This appropriation is provided to cover the cost of furnishing health studies, various health reports, including surveys of physician distribution, public health procedures, and the like to those passing on various public health proposals.	400
543	*Special Bulletins*—This account is used biennially but is budgeted on an annual basis. It covers the cost of special bulletins dealing with proposed changes in laws affecting various public health problems. Usually, any unexpended balance reverts to the general account at the end of each two years	750
544	*Wisconsin Medical Journal Special Inserts*—During many legislative years, special inserts are printed in the *Wisconsin Medical Journal*. This appropriation is budgeted annually and paid in a lump sum to the *Wisconsin Medical Journal* account where it has been fully utilized, inasmuch as the Journal also carries a considerable amount of information relative to activities in other states and nationally.	600
545	*Special Telephone and Telegraph*—This is also an account used only biennially but budgeted annually. Unexpended balances in the odd year may be lapsed.	400
546	*Legislative Counsel*—This is a retainer appropriation paid annually for services rendered chiefly during the legislative session although interim studies of the legislature, as well as of the State Medical Society, also command a considerable amount of time of the legislative counsel. It is important to note that the position of the Society is such that its advice on public health legislation is sought on many occasions. During the current year a staff member of the Society is serving on a special legislative study with reference to the care of the aged, and one of the Society's counsel has been appointed to the committee on accrediting nursing homes, legislation for which was introduced through the State Medical Society and other groups. The amount of time required of legislative counsel during the actual session amounts to more than full-time service of one man for a six months' period.	$3,600
55	PUBLIC HEALTH INFORMATION, PRESS AND RADIO	
551	*Press Releases*—The Society has discontinued the distribution of regular weekly releases to newspapers, but each year requires the preparation of special releases relating to various positions taken by the medical profession, special activities of the Medical Society, such as the Annual Meeting, information to the press relative to content of the *Wisconsin Medical Journal*, particularly that dealing with medical-economic matters. The Wisconsin Press Association handles the distribution of such releases through a special arrangement. This activity should be continued.	400
552	*Health Conferences, Exhibits, and Publications*—The Society sponsored the second Rural Health Conference in 1951 at a cost to itself of approximately $650. In addition, the Society meets requests for exhibits, such as those provided for the Wisconsin Farm and Home Week, the annual meeting of the Farm Bureau, and a special allotment of $200 from this account supports the health activities among the local 4-H Clubs through the state 4-H Club office. In 1951, President Heidner recommended to the House, and authority was given to institute, a series of press-radio conferences in Wisconsin. These are being planned by Doctor Reznichek, a member of the Council on Medical Service; and the first conference will be scheduled in Sheboygan in the spring of this year, with a series to be held in other populated areas. In order to implement the instruction of the House of Delegates, an increased appropriation is needed for the current year. It is also contemplated that a state School Health Conference will be	

Account	Budget Item	Appropriation
	held in the fall of 1952. This will be sponsored jointly with the State Board of Health, the Department of Public Instruction, Public Health Association, School Health Council, PTA, and several other interested organizations. The cost of promotion, speakers, and other items will be in the neighborhood of $600 or $700. It is very possible that some support can be obtained from state agencies and joint-sponsors. In 1952, it is recommended that the Society support, along with other organizations, the publication of a pamphlet for school distribution, and to be sent vocational advisors, relative to training and employment as "medical associates," nurses, laboratory technicians, and so forth. Because the pamphlet has already been printed by the Michigan State Medical Society, it is possible to borrow plates and type and with minor editing, adapt it for circulation in this state. Copies are being provided councilors and officers for review. Cost would be about $800. --	$4,000
5530	*March of Medicine, Recording*—The March of Medicine is carried weekly on 31 radio stations, including six on the WHA (the state station in Madison) FM network. During 1951, Mrs. Stanat, staff assistant, was able to effect a substantial savings by utilizing tapes instead of records which were formerly necessary. This substantially reduces production costs, as well as shipping costs. ---	1,200
5531	*March of Medicine, Supplies*—This account provides a moderate appropriation for replacing tapes, providing mailing cases, and other miscellaneous items. Also included is a sum sufficient for dictating and mimeograph supplies. The program produces "fan mail" varying from 200 to nearly 500 letters a month, with a noticeable slack in the summer months. These inquiries are personally answered by Doctor Parkin with transcription in the office. ----------	750
5532	*March of Medicine, Printing and Postage*—By direction of the Council on Medical Service, health spot announcements are now available to the 71 Wisconsin stations, together with several radio stations in areas bordering on Wisconsin. These are circulated semi-monthly, and the response from the radio stations has been excellent. Content is prepared by Mrs. Stanat, staff assistant. The account also carries postage of 34 cents per tape, and similar items. --	750
554	*Miscellaneous*—This account is for miscellaneous items in the five preceding accounts. ----------	300
56	MEDICAL SERVICE, OPEN PANELS This classification relates only to the preparation and distribution of approximately 80,000 panels provided biennially for posting in plants and other establishments subject to the Workmen's Compensation Act. The project, while carried out in alternate years, requires continuing activity, and amounts are not lapsed, but are treated as a revolving appropriation. Panels are prepared on a county basis and reprints are available in bound volumes to various insurance companies and other organizations desiring them. The income from reprints recovers about $500 of the total expense incurred by the Society.	
561	*Applications and Correspondence*—Members newly enrolled in the Society are circulated as to their desire to be placed on the panel, and in the preparation of the panel itself, all physicians must be contacted for verification of address, telephone numbers, listing under the two specialties available (eye, ear, nose and throat; or eye only). New members sometimes request communications to plants within their areas, advising that their names have been approved for panel listing and will be included on the new panel. --------	$250
562	*Panel Printing*—In 1951–1952, this involves the printing of 80,425 panels county by county; and 100 bound copies. 123,000 form letters are circulated, one series signed by the Industrial Commission and the other by the State Medical Society. -----	2,400
563	*Envelopes*—This covers the purchase of envelopes for panel distribution.	350
564	*Postage and Addressing Costs*—All panel addressing must be by hand and requires the checking of individual records. Labor, utilizing part-time assistance, runs in the neighborhood of $900, with postage amounting to approximately $1,000.	1,300
565	*Miscellaneous Expense.* ----------	200
57	ANNUAL MEETING The Annual Meeting involves 20 separate accounts, and a separate financial report relative to it is distributed to councilors and officers. The Annual Meeting expenses are handled as a revolving account with income from exhibits, luncheons, and miscellaneous items, including the Annual Dinner, turned back to the cost of the meeting. In addition, budgetary allotment is required. The total cost of the Annual Meeting approximates $14,000 annually, and income meets about $12,000 of the total expense. Expenses for the House of Delegates, including the stenotype report and the delegates' handbook, are $1,200. Other major items include the President's Reception, underwriting of the costs of scientific exhibits, speakers, and guests. ----------	1,500

Account	Budget Item	Appropriation
58	TEACHING CLINICS, INDUSTRIAL HEALTH CLINICS, AND COUNCILOR DISTRICT MEETINGS Total appropriations for these three budget items in 1951 was $3,800. Registration fees produced a total income of $3,000 and grants from other organizations to the Society, total $1,200. Other agencies support the program through direct honoraria and travel expense for speakers to the extent of $2,000. The teaching clinics are planned on an academic year, and it is difficult to produce a cost accounting until the whole program is completed. Thus, the report on each of these items as to the actual 1951 expenditures does not reflect the over-all cost of the program, and those figures must be qualified by the fact that, for example, registration fees were collected in 1951 but will be partially expended in 1952.	
581	*Teaching Clinics, General*—This includes the circuit teaching programs (nine individual meetings for three circuits for 1952) and any special meetings that are conducted in cooperation with the American Cancer Society, one being contemplated for 1952. While registration fees are charged, these do not recover the expense of the clinics which involves speaker honoraria, printing and postage, speaker meals, and hotel. Salary and staff travel are not allocated. The State Board of Health, the American Cancer Society, the Wisconsin Heart Association, and the Wisconsin Anti-Tuberculosis Association each participate financially to support certain phases of the clinics. Total support for the clinics in the fall of 1951 and spring of 1952 from these independent agencies totals approximately $4,000. This account is also treated as a revolving account necessitated by the character of the programs conducted. ----------	$1,500
582	*Industrial Health Clinics*—The Industrial Hygiene Unit of the State Board of Health gives financial assistance by way of partially underwriting the printing and postage expenditures and contributing the major support for the reimbursement to speakers, totalling about $1,400, paid directly to the State Medical Society. This is not a standing commitment but is considered annually. In addition, the Society, other than staff assignment, pays for promotional expenses and speaker travel. Three clinics are contemplated for 1952. In 1951, it was possible to operate the Industrial Health Clinics without cost to the Society. However, it is not believed that a "repeat" in finances will be entirely possible in 1952. ---	500
583	*Councilor District Meetings*—In 1951, through the state office, six of these meetings were arranged with the Society underwriting all or part of the scientific program. Small amounts are involved for postage and addressing of envelopes. Because of speaker selection, it is possible in some of the programs to have other agencies pay the honoraria and travel expenses. In some district meetings, such as the Third District, the program continues over the dinner hour, and the registrants pay a sum sufficient to cover their own dinner expense with meals being provided guests gratis. This is also a revolving account in which the budget appropriation does not represent the entire income. ----------	$600
59	WISCONSIN MEDICAL JOURNAL The Wisconsin Medical Journal is provided each member of the Society and to subscribers, advertisers, medical societies, and others to a total of approximately 3,600. In 1951, gratis distribution was authorized to senior medical students of the two medical schools in Wisconsin. This involves an additional circulation of 160 and thus additional cost of printing and postage. A special type of addressing system has been established for this latter distribution, and of course, it is substantially revised each year. In addition, new members of the Society are furnished the permanent Blue Book and the January supplementary issue, as are junior medical students. Some extra expense has been imposed upon the Journal by reason of special pages being made available to the clinical pathologists, the anesthesiologists, the State Board of Health, and others. The Journal is the official publication of the Society and under the Constitution and By-Laws is required to carry certain official reports and notices. For example, the minutes of the House of Delegates for the October 1951 session totalled 49 pages alone. Advertising rates for the Journal are studied annually and are pretty much in line with other state medical journals of comparable size and circulation. Practically all advertising is obtained through the State Journal Advertising Bureau maintained in AMA headquarters by participating journals of most state medical organizations. Advertising policies of the Journal are in conformity with advertising policies of the American Medical Association although some further restrictions have been imposed. This again is a revolving account, and none of the salary of the secretary and assistant secretary is assigned to the Journal. One full-time	

Account	Budget Item	Appropriation
	employee acts as assistant editor, and the salary of that employee is carried from the Journal account. Printing costs have advanced almost 40 per cent in the past several years, and because advertising contracts and rates must be established as much as 18 months in advance, the business management of the Journal is difficult with so limited a circulation in advertising appeal, and at times the problems are wholly unpredictable. For example, a change in postage regulations will involve added costs to the Journal in 1952 amounting to approximately $500. Previous financial support given the Journal is inadequate in light of these several considerations and must be increased substantially if the Journal is to be maintained at its present size and content. In previous years it has been possible to estimate the Journal as costing about $1 to $1.10 per full-time active member. The appropriation suggested would run it to $1.50. It might be added that active membership in the Society has increased a total of about 400 members in the last decade. _____	$4,200
5901	VETERANS AGENCY AND PREPAID PLANS This budgetary item has been generally reorganized in order to present as clear a picture as possible of the character of Society expenditures from the dues account and the necessity for them inasmuch as the programs necessitate expenditures on the part of the Society, which on an accounting basis cannot be justifiably allocated to the program itself. The several prepaid plans, including Surgical Care of Milwaukee, have now enrolled probably more than 800,000 persons. Activities of the AMA, the State Society, and other groups in the prepayment field, urging the extension of voluntary insurance, develop many problems and questions within the office, other than administration of the programs as they now exist. In some areas, special studies and other efforts have been necessitated by reason of local problems. No salaries of the executive staff have in the past been allocated to any of these accounts. It remains the secretary's request, initially made in 1946, that none of his salary be allocated to any of these accounts for the reason that he is the Society's employee as to all matters within its jurisdiction, and no person occupying the position of secretary should be subject to possible influence as to the disposition of problems of the Society by reason of financial considerations personal to himself. The secretary does not object, but on the contrary favors, salary allocations of other employees where such individuals actually work with problems relating to the two agencies. It will be noted that salary allocations are reported in the payroll budget which follows the operating budget of the Society.	
59011	*Wisconsin Physicians Service* — It was unnecessary to make expenditures from this allocation in 1951. In the past it has carried items, relatively minor in individual amount and in which accounting procedures would be too intricate to make it worth while, such as the share of the cost of the physician enrollment blank which is developed for all four activities in the Society, including the Wisconsin Plan, Veterans Medical Service Agency, Open Panel, and miscellaneous. _____	----
59012	*Wisconsin Plan*—In development of the Wisconsin Plan there have been annual preparation and printing of panels of participating physicians made available to people generally interested in the program and on a cost basis to participating insurance carriers and the like. Other expense includes stationery and printing of the Questions and Answers pamphlet. Negotiations are now in process to determine a workable system to recover those charges that are legitimately attributable to reviewing Wisconsin Plan problems, such as claims, policy forms, claim forms, and similar material. The normal expense in the past several years has approximated $3,500 annually without salary allocations. During the year just past, because of extensive developments within the Society itself relating to prepayment insurance a number of matters were held in abeyance including the printing of panels which accounts for the fact that that item was substantially underexpended this year. It is believed that this should not affect the appropriation for 1952. _____	$3,500
59013	*Experimental Programs*—There is one experimental program in operation, and its direction has been assigned to the Commission on Prepaid Plans. This is the Price–Taylor program under which, by contract with the Farm Home Administration, the services of local physicians are provided for clients of that federal agency. These clients, for the most part, are people who are without local credit but who under normal circumstances are capable of providing for their normal needs. Farm Home Administration finances purchasing of farm machinery, and so forth, and is engaged in what amounts to a rehabilitation program. At the request of that administration and with the agreement of the local county medical society, the trial prepaid program was installed,	

Account	Budget Item	Appropriation
	providing home, office, and hospital visits by physicians for a nominal fee of $40 annually prepaid. This fee, covering services provided about 1,300 people, is disbursed quarterly; and the State Society for its part provides a certificate outlining the benefits of the plan, the vouchers for the physicians' bills, and arranges quarterly meetings of a committee which audits all claims. It is likely that the plan will be discontinued in 1952 if it is possible to arrange the installation of the Blue Shield program. This question is under consideration.	$500
59014	*Veterans Medical Service Agency*—The normal annual expense which requires Society underwriting approximates $1,000. Under the contract with the Veterans Administration and the policy of the general accounting office, committee, travel, and meeting expense is nonrecoverable as are a few other items. An effort was made in 1951 to reduce the expenditures by about one-third, but it proved unsuccessful, and consequently, the recommendation is for restoration of the amount provided in prior years. See account number 59022, below, for a special report and recommendation.	1,000
59015	*Actuarial Expense*—It will be recalled that a substantial appropriation, provided as an interim appropriation, was made available for having the advice of an actuary in relation to the Society's activities in prepaid insurance. The original appropriation (1950) was $5,000, and the unexpended balance was carried forward in 1951 in the amount of $3,150. In 1951 this appropriation has been expended. It is suggested that a relatively nominal appropriation will suffice for this purpose in 1952 as much of the actuary's work will be with Blue Shield and will be paid out of the Blue Shield account.	750
5902	Interim and Special Appropriations This account carries appropriations authorized subsequent to the annual session of the Council and miscellaneous appropriations believed to be of a non-recurring nature.	
59021	*Student Loan Fund*—While active solicitation to implement this account has been instituted, it appears necessary that the State Medical Society support it from dues structure until such time as the fund has accumulated a sufficient amount to get into actual operation. Contributions and pledges total $5,000 to date of the preparation of this budget.	3,000
59022	*Veterans Medical Service Agency*—By formal action, the Society has guaranteed that the administrative expenses of this agency will not exceed 12 per cent of total authorizations received from the Veterans Administration. The agency has been operated as economically as possible, but if the current volume continues unchanged, operation expense will have to be adjusted from almost 14 per cent to 12 per cent. It may be impossible to meet the guarantee and continue an effective agency. The whole program is under careful study and evaluation, and with the reduction in volume, it will be noted that executive salary allocation of the director is recommended for change in 1952. This is reflected in the payroll budget. However, the supporting appropriation is required, although it may not be utilized.	$3,000
59023	*State Historical Society, Survey of Medical Records and History*—In the May, 1951, Council meeting, an appropriation of $2,450 was authorized to support the State Historical Society in its study of Wisconsin medical records and history. The Rockefeller Foundation is providing some matching assistance. This is not considered as a project that will need annual appropriations, it being a one-time grant. However, the appropriation is being utilized as services are being performed and certified to us by the State Historical Society.	----
5903	Travel Accounts	
59031	*Secretary's Travel*	3 000
59032	*Assistant Secretary's Travel*—The travel of the assistant secretary in connection with the circuit clinics, health conferences, and the like has been charged in the past into those specific appropriations. It is felt it is better administrative policy to have employee actual travel expense (excluding expenses paid for others) actually shown in the travel account. This accounts for the increase.	1,100
59033	*Director of Public Information Travel*—No effort was made to allocate any part of time to WPS through 1951, but it is anticipated that the allotment suggested is in reasonable amount to be carried by WPS activity.	800
59034	*Field Secretary Travel*—This follows the recommendation in connection with salary that approximately one-third of his activity will arise out of WPS problems. Consequently, one-third of his travel should be borne by that account.	1,600
59035	*Claims Manager and SMS Consultant Travel*—In 1951 and prior years, traveling done by the director of public information, the director of the Veterans Agency, and Doctor Parkin was charged into one account. With Mr. Doran having specific responsibilities in WPS claims, this allocation is anticipated as sufficient.	300

Account	*Budget Item*	*Appropriation*
59036	*Medical Advisor Travel (For radio activity)*—When new stations are added to the March of Medicine or some participating station engages in an anniversary celebration, requests are occasionally received to have Doctor Parkin present a "live" broadcast with attendant local publicity. In addition, the assistant in connection with the March of Medicine is expected to personally visit a good share of the participating stations in order to ascertain problems, perhaps secure a better time for the broadcasting of the program, and to assure a personal interest between the station manager and the State Medical Society. This appropriation is anticipated as including such travel also.	$300
5904–5	EMPLOYEE TAXES AND INSURANCE	
5904	*Group Insurance*	650
5905	*Employment Taxes*	1,300
	Total	$ 91,350
	Payroll as reported in payroll budget.	$ 76,204
	Grand Total	$167,554

In the approval given the budget, it was understood that as in former years unexpended appropriations in certain accounts are treated as carryovers, and in detail they are: (estimated)

Account 536	Accounting and Insurance	$ 1,200
5311	Upkeep and Fixtures	350
5312	New Equipment	300
562	Panel Printing	1,250
564	Postage and Addressing Costs	600
57	Annual Meeting	1,500
581	Teaching Clinics, General	2,000
583	Councilor District Meetings	250
59023	State Historical Society, Survey of Medical Records and History	1,125
	Total	$ 8,575

Payroll Budget 1952

1. Secretary salary	$17,500
2. Assistant Secretary	10,725
3. Claims Director of Prepaid Plans and Veterans Agency Director, allocation from budget (total annual salary $10,450)	1,800
4. Director of Public Information, allocation from budget (total annual salary $7,500)	5,000
5. Field Secretary, allocation from budget (total annual salary $5,400)	2,900
6. Comptroller, allocation from budget (total annual salary $7,500)	3,000
7. For four positions of executive assistant	13,055
8. For three positions of administrative assistant	7,247
9. For five secretaries	12,509
10. For one clerk	1,968
	$75,704
And for payroll adjustments	500
	$76,204

5. Report of the Treasurer

Dr. F. L. Weston, treasurer, presented the following report for the year ended December 31, 1951, which was approved on motion of Doctors Dessloch–Bell, carried:

THE STATE MEDICAL SOCIETY OF WISCONSIN
Madison, Wisconsin
REPORT OF DR. F. L. WESTON, TREASURER
For the Year Ended December 31, 1951

Cash on Deposit—First National Bank, January 1, 1951		$ 15,970.14
Receipts		
Membership Dues	$141,424.74	
1951 Exhibit Space Rentals	6,983.75	
1952 Advance Exhibit Space Rentals	5,202.75	
Panel Receipts—Wisconsin Plan	83.50	
Panel Receipts—Workmen's Compensation	330.00	
Rural Health Conference Reports	172.10	
Annual Meeting Round-table Receipts	4,011.50	
Postgraduate Clinic Receipts	10,826.50	
Interest Received	392.15	
Principal Collected on Aetna Insurance Policy	418.00	
Reimbursement of Expenses by Wisconsin State Advisory Committee to Selective Service	342.65	
Total Receipts		170,187.64
Total		$186,157.78
Disbursements		
Constitutional Officers and Committees		
President's Travel	$ 500.00	
Council and Committees	16,474.16	
Books and Periodicals	780.15	
Auxiliary	200.00	
Secretary's Salary	15,253.20	
Secretary's Travel	3,632.99	
Group Total	$ 36,840.50	
Organization—Staff		
Assistant Secretary's Salary	$ 9,750.00	
Assistant Secretary's Travel	690.33	
Executive Staff Salaries	18,772.27	
Group Total	$ 29,212.60	
Administrative Expense		
Accounting and Insurance	$ 5,087.66	
Social Security and Unemployment Compensation Taxes	1,312.06	
Rent	6,009.00	
Telephone and Telegraph	2,279.83	
Current Supplies	3,305.03	
Postage and Printing	4,008.32	
Fixtures and Upkeep	548.09	
New Equipment	939.74	
Miscellaneous	1,177.69	
Group Insurance	661.40	
Group Total	$ 25,328 89	
Membership—Special Service		
Legal	$ 3,104.25	
Bulletins to Members	549.56	
Blue Book Issue	750.00	
Group Total	$ 4,403.81	
Public Health—Normal Service		
Today's Health	$ 399.00	
Lay Publications	672.85	
Special Bulletins	307.37	
Special Reports in the Journal	1,300.00	
Telephone and Telegraph	149.18	
Legislative Counsel	3,000.00	
Veterans Medical Care and Prepaid Medical Care Plans:		
Stenographic Assistant	1,900.50	
Wisconsin Plan	1,471.25	
Experimental Program	473.66	
Veterans Medical Service Agency	977.35	
Group Total	$ 10,651.16	
Public, Industrial and Rural Health, and Public Instruction		
Wisconsin Plan Director	$ 2,300.00	
Executive Director—Public Information	6,500.00	
Staff Appropriations	4,616.70	
Staff Travel	1,589.03	
Press Releases	444.62	
Health Exhibits and Conferences	1,219.43	
Radio Programs:		
Honorarium to Medical Director	1,800.00	
Recording and Disks	1,557.23	
Supplies, Express, and Postage	1,383.48	
Printing	167.23	
Industrial Panels of Physicians:		
Applications and Correspondence	145.35	
Printing and Distribution	652.43	
Part-time Help, Postage and Miscellaneous	896.59	
Miscellaneous	53.14	
Group Total	$ 23,325.14	
Totals—carried forward	$129,762.03	$186,157.78

Totals—brought forward	$129,762.03	$186,157.78
Annual Meeting, Teaching Clinics, and Wisconsin Medical Journal		
Annual Meeting	$ 17,309.97	
Postgraduate Clinics	7,161.02	
Councilor District Meetings	257.96	
Wisconsin Medical Journal	3,000.00	
Group Total	$ 27,728.95	
Other Expenditures		
Interim Appropriations:		
Actuarial Expense	$ 4,571.24	
State Historial Society	1,325.00	
Student Loan Fund	3,000.00	
Legal Expense—Student Loan Fund and Special Fee Study	485.00	
National Conference on Medical Service	652.21	
Selective Service Expense	36.00	
Refundable Expenditures—Wisconsin Physicians Service	66.59	
Group Total	$ 10,136.04	
Total Disbursements		167,627.02
Cash on Deposit—First National Bank, December 31, 1951		$ 18,530.76

Balance Sheet December 31, 1951

Assets	
Cash on Deposit at First National Bank of Madison—Treasurer's Account	$ 18,530.76
Cash on Deposit at American Exchange Bank of Madison—Secretary's Petty Cash Account	300.00
Cash on Deposit at American Exchange Bank of Madison—Secretary's Dues Account	432.50
U. S. Treasury Bonds	14,240.63
Advance to Wisconsin Veterans Medical Service Agency	7,500.00
Advances to Wisconsin Physicians Service	29,066.59
Advances to The State Medical Society of Wisconsin Building Fund	71,500.00
Advance to Secretary's Working Fund	500.00
Total Assets	$142,070.48
Reserves and Surplus	
Reserve for 1952 Advance Exhibit Space Rentals	$ 5,202.75
Reserve for Dues	332.50
Society's Surplus	136,535.23
Total Reserves and Surplus	$142,070.48

6. Councilor District Reports

A report was made by each councilor as to conditions within his councilor district.

7. Election of Officers

a. *Chairman of the Council*—Doctor Gavin assumed the chair for this order of business. On motion, carried, Doctor Arveson was re-elected chairman of the Council for the ensuing year.

b. *Treasurer*—On motion, carried, Doctor Weston was re-elected treasurer of the Society for the ensuing year.

c. *Secretary*—On motion, carried, Mr. Crownhart was re-elected secretary of the Society for the ensuing year.

8. Special Election—Vice-Speaker of the House of Delegates

On motion of Doctors Kasten–Heidner, carried, Dr. W. D. Stovall was appointed vice-speaker of the House of Delegates for the balance of the term created by the succession of Dr. H. Kent Tenney to the office of speaker.

9. Election of Medical Editor

On motion of Doctors Tenney–McCarey, carried, Doctor Baldwin was re-elected medical editor of the *Wisconsin Medical Journal* for a two-year term.

10. Election of Editorial Director

On motion of Doctors Dessloch–Kasten, carried, Doctor Sullivan was re-elected editorial director of the *Wisconsin Medical Journal* for a one-year term.

11. Election to the Interim Committee

The term of Dr. J. C. Fox expired at this time. On motion of Doctors Kasten–Dessloch, carried, Doctor Fox was re-elected to the Interim Committee for the term expiring in 1955.

12. Interim Reports

a. *Wisconsin Veterans Medical Service Agency*—Doctor Supernaw, chairman of the Agency, presented a report of the value and number of authorities for claims and the per cent of the total authorization spent for administration, as follows:

	Value	Number	Per cent for Administration
1950	$210,615	15,467	11
1951	170,193	13,993	13.6

Doctor Supernaw urged the continued support of the home-town medical care program for veterans with service-connected disabilities. He stated that he would soon go to Washington to negotiate with the Veterans Administration with regard to the agency contract for 1952, and he feared that an attempt would be made by the Veterans Administration to cut the administration expense to 10 per cent or lower.

The Council reaffirmed its action of November 1951, approving operation of the Veterans Medical Service Agency on the basis of 12 per cent of the amount of money authorized for claims.

b. *Wisconsin Physicians Service*—Doctor Dessloch, chairman of the Commission on Prepaid Plans, called attention to two items on the agenda relating to the prepayment plans:

(1) Anesthesia Benefits—Prepaid Plans. At the first meeting of the Commission on Prepaid Plans in December 1951, action was taken to provide that anesthesia benefits may be paid to the doctor who performs surgery, as well as gives the anesthetic, and bills for both services. This action removes a restriction approved by the Council in its report to the House of Delegates in October 1951, and accepted by the House in adopting the report, namely, that anesthesia benefits are provided when performed by a physician other than the physician in charge of the case. The Executive Committee of the Commission reported this action to the Council for action.

On motion of Doctors Bell–Fox, carried, the Council approved the action of the Commission on Prepaid Plans with respect to anesthesia benefits.

(2) Request of Commission on Prepaid Plans to Write Indemnity Insurance. Doctor Dessloch emphasized that Wisconsin Physicians Service, through its agent, would sell the full payment program wherever possible, but requested, on behalf of the Commission on Prepaid Plans, Council authority to write indemnity insurance, to which full payment shall not attach, to meet such problems as exemplified in the following situation:

In presenting Blue Shield to a prospective purchaser, he is willing to accept the scheduled benefits for surgery and medical care, but does not want to pay the additional rate necessary to accept the specified benefits in radiology or anesthesiology. He is willing to pay a lesser rate and purchase a benefit that is in the present schedule and is not full payment. Denial of such request might result in the loss of the sale.

On motion of Doctors Bernhart–Kasten, carried, the Council granted authority to the Commission on Prepaid Plans to write indemnity coverages to which full payment is not attached.

c. *Report of Legal Counsel*—Mr. Murphy, legal counsel for the Society, reported that his services, and those of his firm, fall under three major categories: legislative, Wisconsin Physicians Service, and general services to the Society.

Included in the matters confronting legal counsel during the past year were participation in the studies of the special fee committee, the Wisconsin Plan, Wisconsin Physicians Service, and Coordinating Committees, assisting in the preparation of the report concerning the revision of the prepayment plans for the House of Delegates, and subsequent revision of the contract and the fee schedule.

In the legislative field, counsel has conducted interim legislative studies, and has followed the work of the Wisconsin Legislative Council, the legislative program of the A. M. A., and federal legislation concerning health and related fields.

General services include assistance in revising the Blue Book issue of the *Wisconsin Medical Journal*, revision of the income tax article, preparation of the employee retirement program, review of the Society's insurance, negotiations with Wisconsin Plan insurance companies, liaison with the actuary and accountants, and meetings with various Society committees.

d. *Report of the Secretary*—Mr. Crownhart explained the administrative structure of the Society office, which is planned so the normal activities can be carried on in case of the absence of staff members. In order to retain the basic concept of the Society, that of serving the individual physicians of the state, Mr. Crownhart urged that the councilors and officers, through correspondence between meetings of the Council, take an active interest in the activities of the Society to keep the direction of policy in the profession.

He reported that monthly staff meetings are held to acquaint all members with current and proposed projects; meetings are held monthly with the staff of Blue Cross; and the Grievance Committee met with the Committee on Interprofessional Relations of the State Bar Association and a program of closer relations with the legal profession is contemplated.

13. Report of Interim Committee

a. *Sponsorship of Film—"Cheers for Clubby"*—The State Medical Society had been asked to cosponsor the film, which deals with the subject of overweight and is in the style of an animated cartoon, with the State Board of Health, the American Medical Association, the Federal Security Agency, and the Metropolitan Life Insurance Company. The sponsorship involves the preparation of a letter announcing the showing in Wisconsin theaters during March, and the supply of letterheads and envelopes. The Interim Committee recommended approval of the project.

On motion of Doctors Dessloch–Fox, carried, the recommendation was approved.

b. *Costs of Hospitalization*—The Interim Committee referred two matters to the Council on Medical Service for study and recommendation to the Interim Committee and the Council; one concerns the practice of at least one Wisconsin hospital of requiring a routine blood pressure upon admission, and the hospital charges for that service; the other involves a proposal of the Chicago Medical Society that the medical staff of each hospital be required to automatically cancel orders for medications after three days, unless renewed by written order, or unless a longer period is specified originally. No Council action was taken.

c. *Meeting of the Council at the time of the 1952 Wisconsin Rural Health Conference*—It had been suggested that arrangements be made for a formal session of the Council at the time of the Wisconsin Rural Health Conference, probably in September 1952, so that the councilors and officers will have the opportunity of attending these important meetings. The Interim Committee approved the suggestion, and on motion of Doctors Kasten–Fox, carried, the Council directed that such plans be made.

d. *Reporting Committee Activities in Wisconsin Medical Journal*—On motion of Doctors Bell–Kidder, carried, the Council approved the recommendation of the Interim Committee that there be published in the *Wisconsin Medical Journal* monthly a brief report of activities of the various committees of the Society.

e. *Special Meeting of the House of Delegates*—The suggestion had been made that an additional meeting of the House of Delegates be called for an educational program in the field of medical economics. While the Interim Committee felt that there was considerable merit to the suggestion, it recommended that no formal action be taken, in view of the problem of holding the session at a time generally convenient, the expense involved, and the fact that information of an educational character is available to the delegates through the *Wisconsin Medical Journal*, and other material circulated to the delegates.

On motion of Doctors Dessloch–McCarey, carried, the Council approved the recommendation of the Interim Committee.

f. *1954 National Rural Health Conference*—On motion of Doctors Fox–Dessloch, carried, the Council approved the recommendation that the Council and officers formally invite the A. M. A. to hold the 1954 National Rural Health Conference in Milwaukee.

g. *Wisconsin Pharmaceutical Association Current Litigation*—The Attorney General recently ruled relative to the dispensing of drugs in a physician's office. The Wisconsin Pharmaceutical Association is in disagreement with the Attorney General's opinion and has brought a lawsuit intended to secure its reversal. The Interim Committee believes that the Attorney General's opinion is a realistic interpretation of the law and is sound in its expression of public health interests involved, and recommended that legal counsel and the secretary's office be authorized to actively express the interest of the State Medical Society with respect to the matter.

On motion of Doctors Bell–McCarey, carried, the Council granted such authority.

14. Recommendation of Grievance Committee

Doctor Fitzgerald, chairman of the Committee on Grievances, requested authority from the Council, when confronted with the problem of a narcotic addict attempting to secure narcotics from Wisconsin physicians, to circulate a description and general information about the addict to the members of the Society. The *Journal of the American Medical Association* has, on occasion, carried descriptions with a warning to physicians.

On motion of Doctors Bell–Bernhart, carried, the authority was granted.

15. Report of Council Committee on Blood Banks

Doctor Stovall, chairman of the Committee on Blood Banks, requested approval of the following four recommendations with respect to the blood procurement program in Wisconsin:

1. That the State Medical Society, through correspondence over the signature of the President or Chairman of the Council, contact county medical societies, urging their more active participation in the blood procurement program, and encourage them to work out a plan whereby local medical assistance can be given the mobile units when they visit the communities within the county.

2. That steps be taken through publication of special materials in the Journal, and through follow-up communications to hospitals, so that more attention will be directed to proper use of blood without waste.

3. That the Committee on Blood Banks be used as an advisory committee to any procurement program in the state which seeks guidance, and that in those areas where there is overlapping of services, the committee assist in developing a coordinated program.

4. That the Committee on Blood Banks work in cooperation with Civilian Defense leaders to develop a program of storage of plasma for any possible disaster, and help formulate recommendations to the Governor and General Olson in respect to a program which will be realistic and provide a method of rotation of supplies so that civilian needs throughout the year can be met and yet have an oversupply of plasma which can be utilized in event of a major catastrophe.

On motion of Doctors Kasten–Bell, carried, the recommendations were approved, and the committee continued for another year.

16. Employee Retirement Program

On motion of Doctors Fox–Kasten, carried, the following retirement plan for State Medical Society full-time lay staff was approved, and authority for its installation was delegated to a special committee composed of Doctor Dessloch, as chairman of the Audit and Budget Committee; Doctor Arveson, as chairman of the Council; and Doctor Weston, as treasurer of the Society:

A. Pension Plan (Participation by employee is optional as now proposed)

1. *Proposed Effective Date*—July 1, 1952.

2. *Eligibility*—All lay employees of The State Medical Society of Wisconsin whose annual salary is in excess of $3600 as of the effective date and who have completed three years of service and who have not yet reached their 50th birthday shall be eligible to participate in the plan.

All other and all future employees shall be eligible to participate on the anniversary of the effective date of the plan following the date on which the employee's annual rate of compensation is first in excess of $3600 providing that they have completed three years of service and have not then reached their 50th birthday.

3. *Normal Retirement Date*—Normal Retirement Date (not compulsory) shall be the anniversary of the effective date nearest to the participant's 65th birthday.

4. *Retirement Income*—All covered employees will receive, commencing at normal retirement, 1 per cent of annual salary as of the date they enroll in the plan, times the years of service prior to that date. All employees who elect to participate in this plan shall receive an annual future service retirement income of 1 per cent of average annual salary, while a participant, times the number of years of participation in this plan.

For the purpose of determining the amount of retirement income, no increase in salary shall be considered after the anniversary of the plan 10 years prior to Normal Retirement Date.

5. *Range of Monthly Benefits*—The minimum retirement income commencing at 65 will be $20 a month, and the maximum about $270. The proposed benefits are exclusive of and in addition to any benefits under social security.

6. *Contributions*—An employee who elects to participate in the plan will contribute 40 per cent of the cost of purchasing his benefits. The State Medical Society of Wisconsin will contribute 60 per cent of the cost of purchasing the benefits.

7. *Vesting*—Upon termination of employment a participant may elect to withdraw from the plan or to leave his contributions with the insurance company and to receive a paid up annuity commencing at Normal Retirement Date. If he elects to withdraw, his contributions plus interest or 40 per cent of the cash value of the policy, whichever is larger, will be paid to him. If he elects to leave his contributions with the company, a paid up deferred annuity, commencing at Normal Retirement Date, will be purchased for him.

8. *Death Benefits*—Upon death prior to retirement the beneficiary will receive the participant's contributions plus interest or the portion of the cash value which is vested in the participant, whichever is greater.

Upon death after retirement the beneficiary will receive a continuation of the participant's annuity for the remainder, if any, of the 10 year period subsequent to Normal Retirement Date.

It is also proposed that a $5,000 death benefit be available *in addition to* the 10 year annuity described above. The reason for putting that benefit into this part of the program is that the group life portion of the program is limited to $5,000 in so small a group. In order to get a $10,000 life insurance program it was necessary that one-half of it come through the annuity program and the remainder through the group life program.

Carrying the life insurance through the annuity portion of the program has the effect of reducing proposed retirement benefits by about 10 per cent, but also decreases the cost to the State Medical Society and the employees.

B. Life, Double Indemnity, and Time Loss Coverage

At least 75 per cent of all eligible employees must enroll before this part of the program can become effective. Despite the limited number of employees, the proposal is based on a true group rate.

1. It is proposed that all lay employees of the Society who have completed 6 months and whose annual salary exceeds $3600 (9 such employees at present) have the following coverage:

(a) $5,000 life insurance.
(b) $5,000 accidental death and dismemberment.
(c) $40 weekly indemnity for total disability from accident or sickness.

2. It is proposed that all lay employees of the Society who have completed 6 months and whose annual salary is $3600 or less (28 such employees at present) have the following coverage:

(a) $2,000 life insurance.
(b) $2,000 accidental death and dismemberment.
(c) $20 weekly indemnity for total disability from accident or sickness.

C. Estimated Combined Costs of Above Programs

	Total	Less Employee Contribution	Net Cost to Society
Pension Plan (A)	$5,203.44	$2,081.64	$3,121.80
Insurance Plan (B)	2,032.80	1,320.00	712.80
	$7,236.24	$3,401.64	* $3,834.60

17. Time Schedule of House of Delegates

The Council on Scientific Work recommended that the Council consider scheduling the meetings of the House of Delegates on Saturday and Sunday, with the final session on Monday morning, so that the delegates would be free to attend scientific meetings on Monday. This would mean that the general membership would not have the opportunity to appear before the reference committees that it has with the present schedule of holding business meetings on Sunday afternoon, Monday night, and Tuesday morning.

On motion of Doctors Dessloch–Kidder, carried, the Council determined that the present time schedule should be continued.

18. Sponsorship of Public Meeting, October 8

As a part of the scientific program on Wednesday, October 8, at the time of the Annual Meeting, there will be a symposium on "Growth Requirements in Childhood." Invitations have been extended to Philip Jeans, M.D., Children's Hospital, Iowa City, to discuss "Nutritional Factors in Growth;" E. S. Gordon, M.D., University of Wisconsin, to discuss some phase of endocrine problems in growth; and Milton Senn, M.D., New Haven, Connecticut, to discuss "Emotional Problems in Growth."

It had been suggested that the program be repeated on the lay level at the Milwaukee Vocational School Wednesday evening, under the joint sponsorship of the State Medical Society, the Milwaukee Council of Parents and Teachers, and other interested parties.

On motion of Doctors Dessloch–Tenney, carried, the Council approved the proposal that these arrangements be made.

19. Department of Veterans Affairs

The Department of Veterans Affairs advised that one additional member could be recommended to the Board of Veterans Affairs to serve on the Medical Advisory Committee; in addition, the department suggested certain physicians to fill the vacancy caused by the death of Dr. Byron Hughes.

On motion of Doctors Fox–Dessloch, carried, the Council recommended the three physicians, the Board to choose the replacement and additional member.

20. Plans for Next Meeting

The Council has directed that annual conferences be held with members of the State Board of

* The allocation of the Society's share to Wisconsin Physicians Service and other funds in accordance with salary allocations would reduce the financial burden on the general funds of the Society to a figure estimated at somewhat less than $3,000.

Health, State Board of Public Welfare, and State Board of Medical Examiners, and biannual conferences with Wisconsin's delegates to the American Medical Association. For several years, the conference with members of the State Board of Health has been held at the time of the Annual Meeting. The secretary was instructed to arrange conference with the other three groups during the next Council meeting in May.

21. Adjournment

The meeting adjourned at 12:20 p. m., Sunday, February 24, 1952.

C. H. Crownhart
Secretary

Approved:

R. G. Arveson, M.D.
Chairman of the Council

ANNOUNCEMENT OF REGULAR CORPS EXAMINATION FOR MEDICAL OFFICERS

United States Public Health Service

A competitive examination for appointment of Medical Officers to the Regular Corps of the United States Public Health Service will be held on June 3, 4, and 5, 1952. Examinations will be held at a number of points throughout the United States, located as centrally as possible in relation to the homes of candidates. Applications must be received *no later than April 30, 1952.*

The Regular Corps is a commissioned officer corps composed of members of various medical and scientific professions, appointed in appropriate categories such as medicine, dentistry, nursing, engineering, pharmacy, etc.

Appointments will be made in the grades of Assistant Surgeon (equivalent to Navy rank of Lieutenant (j.g.) and Senior Assistant Surgeon (equivalent to Lieutenant). In making assignments, consideration is given to the officer's preference, ability, and experience; however, all commissioned officers are subject to change of station and assignment as necessitated by the needs of the Service. Appointments are permanent in nature and provide opportunities to qualified physicians for a life career in clinical medicine, research, and public health. Applicants who successfully complete this examination may ordinarily expect appointment as soon as they become eligible.

Requirements:

Both grades: United States citizenship. At least 21 years of age. Graduation from a recognized school of medicine.

Assistant Surgeon: At least seven years of educational training and professional experience subsequent to high school.

Senior Assistant Surgeon: At least ten years of educational training and professional experience subsequent to high school.

Applicants who meet these qualifications within nine months of the date of the written examination will be admitted, but may not be appointed until they fulfill the requirements. Physicians who are successful in the examination and are now serving internships will not be placed on active duty in the Regular Corps until completion of internship. The examination will include an oral interview, physical examination, and written objective tests covering the professional field.

The written professional examination for the grade of Assistant Surgeon covers the following material: basic medical sciences, including anatomy, physiology, biochemistry, microbiology, and pathology; practice of medicine, including internal medicine (including neurology and psychiatry), therapeutics and toxicology, pediatrics, and medical problems of obstetrics and gynecology; practice of surgery, including surgery, orthopedics, gynecology, obstetric procedures; and preventive medicine and public health. The examination for Senior Assistant Surgeon will include the above subjects with the exception of anatomy.

Physical Requirements: Candidates must be found physically qualified as a result of an examination performed at a Public Health Service facility. The physical standards for appointment to the Commissioned Corps are relatively high. Candidates who have a physical defect, or who have had serious illness or injury, should attach a statement to their applications outlining in detail the nature of such illnesses or injuries, treatment received, periods of hospitalization, length of absence from work, and present status.

Application forms and additional information may be obtained by writing to the Surgeon General, United States Public Health Service, Federal Security Agency, Washington 25, D. C. Attention: Division of Commissioned Officers.

COMMITTEE *Concentrates*

SPECIAL COMMITTEE ON AUTOPSY CODE

MARCH 10

MDs Present: Gorton Ritchie, Joseph Kuzma, E. R. Strauser.

Meeting with representatives of Wisconsin Funeral Directors Association, Wisconsin Hospital Association, and State Board of Health to give further consideration to Code of Autopsy which had been prepared by representatives of the Wisconsin Association of Pathologists and approved by the Council in February 1951 . . . major differences between funeral directors and pathologists the matter of time element, between death and release of body for embalming, and alleged misrepresentations of physicians as to the nature of an autopsy, with resulting regret on part of relatives that they had signed a consent form . . . various revisions made, and the revised code to be considered by Funeral Directors Association and Hospital Association as soon as possible . . . if and when approved, to be submitted to Council for action, and then distributed to all hospitals and funeral directors, as well as the medical profession . . . matter still pending, and cannot be classified as a "dead issue."

SCHOOL HEALTH PLANNING COMMITTEE

MARCH 18

MDs Present: A. H. Heidner, E. H. Pawsat.

Meeting with representatives of Wisconsin School Health Council to implement suggestion of Council of State Medical Society that a state-wide school health conference be held next fall, as follow-up of National Conference on Physicians and Schools of the A.M.A. at Highland Park last November. . . . Plans made to hold the Wisconsin conference at the Memorial Union, Madison, on October 17–18. . . . Framework of conference determined and will be cleared through School Health Committee of SMS and other sponsoring organizations, including U. of W. School of Education, State Board of Health, and Department of Public Instruction.

EXECUTIVE COMMITTEE COMMISSION ON PREPAID PLANS

MARCH 19

MDs Present: E. M. Dessloch, J. S. Supernaw, H. E. Kasten, Robert Krohn.

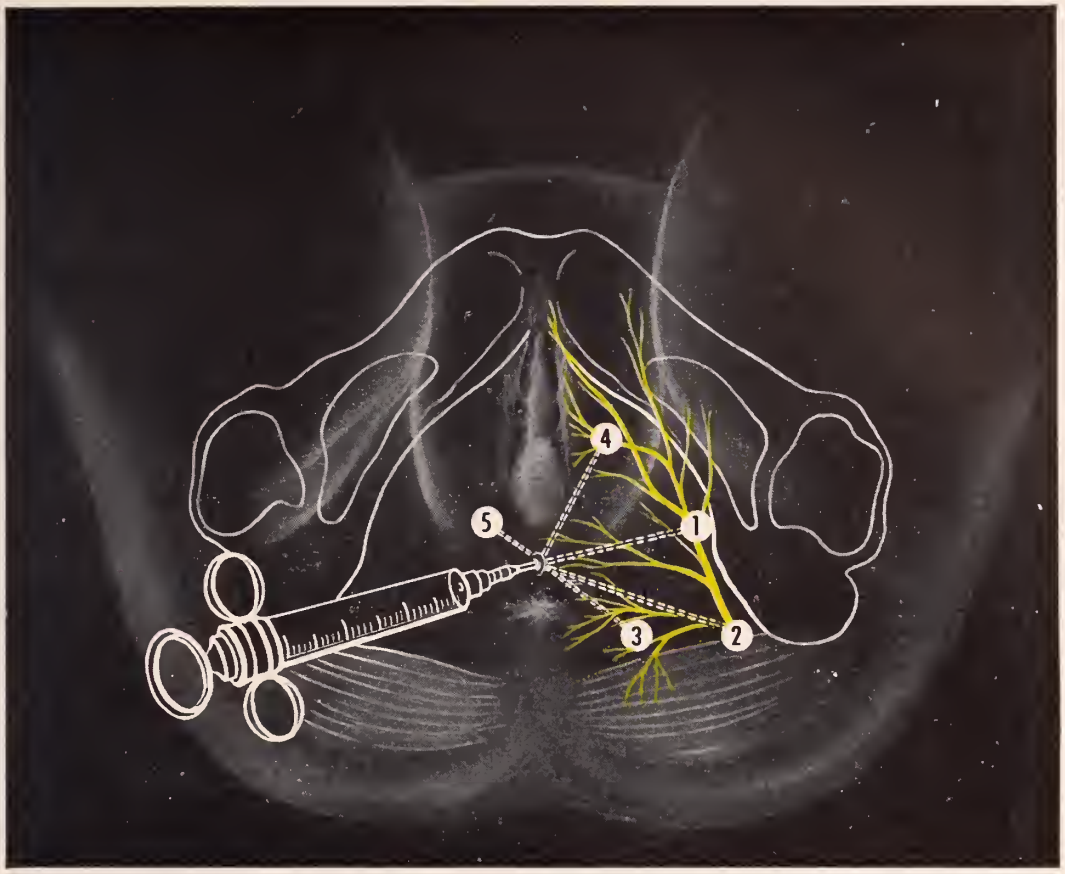
Approved design and style of new Group Service Contract. . . . Received a report by Mr. Murphy with respect to status of approval of new contract by Wisconsin Insurance Department and Wage Stabilization Board. . . . Instructed the staff to prepare a separate indemnity contract, not in the name of Wisconsin Physicians Service, to provide indemnity benefits for anesthesia, radiology, and medical care. . . . Approved revised Physician's Service Report form subject to review of printed copy. . . . Approved bulletin to the membership announcing the new program April 1, and the entire publicity program with respect to the new program. . . . Received report of the actuary on experience rating.

COUNCIL ON SCIENTIFIC WORK

MARCH 21

MDs Present: W. S. Bump, T. O. Nuzum, P. A. Midelfart, S. A. Morton, W. S. Middleton (guests J. P. Conway, Einar Daniels, R. T. Rank, F. J. Stoddard)

Main purpose of the meeting to perfect details of the 1952 Annual Meeting program . . . except for Section on Opthalmology and Otolaryngology, all other sections are to be incorporated into general scientific programs on Tuesday and Wednesday, with emphasis on symposiums. . . . Approved suggestion of Council that if speakers on pediatric symposium on "Developmental Requirements in Childhood" can be prevailed upon to stay over on the night of October 8th, a public meeting be planned in cooperation with Wisconsin Congress of Parents and Teachers. . . . Discussed possibility of incorporating television into 1953 program, and authorized initial contacts with Smith, Kline & French, to see what can be arranged.



Sites for injection of local anesthesia in obstetrics. Sites 1 to 4 should be similarly injected on the contralateral side. Site 5 is for episiotomy. Adapted from Johnson, O. J.: Nerve Block in Painless Childbirth, J.A.M.A. *145*:401 (Feb. 10) 1951.

Pudendal Block in Obstetrics Simplified with **ALIDASE**

Using a local anesthetic with hyaluronidase, Heins[1] reports: "Complete perineal anesthesia is practically instantaneous. . . . The technique of pudendal block is greatly simplified. The operator does not have to inject the nerve per se, but infiltration in the vicinity of the nerve will accomplish an effective block."

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[1]Heins, H. C.: Pudendal Block with Hyaluronidase, J. South Carolina M. A. *46*:309 (Oct.) 1950.

[2]Baum, F. E.: The Use of Hyaluronidase in Pudendal Block, Am. J. Obst. & Gynec. *60*:1356 (Dec.) 1950.

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AUDIT AND BUDGET

MARCH 22

MDs Present: E. M. Dessloch, J. M. Bell and J. C. Fox.

Regular quarterly meeting to review expenditures of SMS and to consider special projects to be reported to the Council. . . . Recommended to Council that Auxiliary be granted $250 to assist Department of Nursing Education to prepare loose-leaf notebook for all high schools, giving detailed information on opportunities in nursing field, and facts on all nursing schools in the state.

COMMITTEE ON HEARING DEFECTS

MARCH 26

MDs Present: T. L. Tolan, J. A. Hurlbut, W. C. Randolph, J. W. Tanner, Maxine Bennett.

Primary purpose to review in detail the state-wide program of screening and follow-up through otologic clinics of the Bureau of Handicapped Children of the Department of Public Instruction. . . . Program the most comprehensive of any state in the nation, and being developed with the closest of medical guidance . . . entire state has been served, and a long-range program of having screening programs every year in one-third of counties, on a rotating basis, and on an annual basis in 25 urban centers where speech correctionists available as outlined and approved . . . general policy of using trained lay personnel for screening also approved . . . suggestion made that subject of otology be scheduled for some of the postgraduate teaching programs offered through SMS.

RELATED ACTIVITIES

While fewer formal committee meetings were held in March, a great deal of work was being done related to committee work. . . . Major effort has been that of getting the new insurance programs started . . . meetings held with Blue Cross representatives to set up time table for publicity, optional selling of new contract, obligatory selling date, and meeting anticipated situations during transition period . . . meeting of all Blue Cross–Blue Shield salesmen held in Madison on March 31–April 1, to get them acquainted with basic provisions of new program. . . . Successful Industrial Health Clinic held in Milwaukee on March 13 (with over 300 MDs, industrial health nurses, and management representatives in attendance) and a second successful one held in Eau Claire on April 2, with more than 100 in attendance) . . . series of Medical–Press Conferences being planned under sponsorship of Council on Medical Service. First one scheduled for May 1 at Sheboygan. . . . Special meeting with representatives of Dane County Medical Society and interested lay groups to review dramatized broadcast of actual "Birth of a Baby," which was produced by a Madison radio station in cooperation with the Dane County Society. Was initially broadcast on March 29, and is scheduled for a national hook up airing later.

SUMMER CAMP SCHEDULED FOR DIABETIC CHILDREN

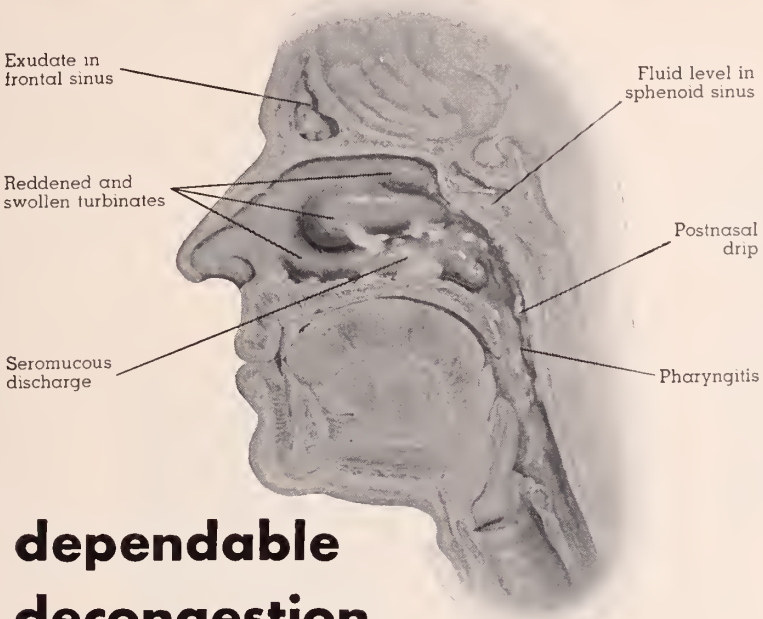
A summer camp for diabetic children will be opened for the fourth season under the auspices of The Chicago Diabetes Association, Inc. from July 1, 1952 to July 22, 1952 at Holiday Home, Lake Geneva, Wisconsin.

In addition to the regular personnel of the camp, there will be a staff of dietitians and resident physicians, trained in the care of diabetic children, furnished by The Chicago Diabetes Association.

Boys and girls, ages eight to fourteen years inclusive, will be accepted at a fee of $120.00 (which covers the three week camping period and transportation from Chicago). Fee reductions may be arranged when considered necessary.

Physicians are requested to notify parents of diabetic children and to supply the names of children who would like to attend camp. Applications may be obtained from, and inquiries should be addressed to: Service Unit, Chicago Diabetes Association, 110 South Dearborn Street, Chicago 3, Illinois.

Limited capacity requires prompt application.



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SOCIETY PROCEEDINGS

Brown–Kewaunee–Door

MERLE O. HAMEL, M. D.

The March meeting of the Brown–Kewaunee–Door County Medical Society was held on the 13th at the Beaumont Hotel in Green Bay. *Dr. John W. Thoma*, clinical instructor of obstetrics and gynecology at Marquette University School of Medicine addressed the members on the subject of "The Indications for Induction of Labor." *Dr. Merle O. Hamel*, Madison, director of the Badger Regional Blood Center, and Mr. John Torinus, chairman of the blood program for the Brown County division of the American Red Cross were also guests of the Society. They discussed the Brown County blood bank program.

Douglas

The Douglas County Medical Society recently met to elect officers for 1952. *Dr. C. T. Droege*, Superior, will head the Society as president, and *Dr. R. T. Anderson*, also of Superior, will serve as secretary.

Fond du Lac

Dr. B. A. Waisbren, clinical instructor in medicine at the Marquette University School of Medicine, addressed the members of the Fond du Lac County Medical Society at their February 28 meeting. His topic was "Modern Use of Antibiotics." Also on the program for the evening were, Dr. D. D. Willson, Fond du Lac, who discussed the new mothers' classes which are being conducted at the Fond du Lac Vocational School, and *Dr. H. J. Kief*, city health officer, who reported on the recent meeting on migrant worker problems which was held by the State Society in Madison.

At the March 27 meeting of the Society another Marquette professor, *Dr. James E. Conley*, associate clinical professor of surgery, was the principal speaker. His subject for the evening was "Surgery of the Sympathetic Nervous System." Special guests at the meeting were *Dr. William Temple*, Milwaukee, and Mr. Roy T. Ragatz of the State Society office.

Green Lake–Waushara

Meeting at Norton's Marine Dining Room in Green Lake on March 27, the members of the Green Lake–Waushara County Medical Society heard a talk by Miss Irene Lewis, Green Lake County nurse, on the projected plans for pre-school child examinations. After a discussion of the proposal, the Society recommended that a fee of $3.00 be set as a guide for charges and that the parents should also be responsible for any extra tests or x-rays. The Society approved the action taken by its Auxiliary to set up a scholarship of $200 to aid nurse recruitment in the two counties.

Jefferson

P. A. DUEHR, M. D.

The most recent meeting of the Jefferson County Medical Society was held on March 20 at Chauncey's Steak House in Pipersville. *Dr. P. A. Duehr*, Madison, who was the guest speaker, chose "White Pupillary Reflex" as the subject for his address.

Kenosha

Dr. Anthony V. Partipilo, Chicago, was the speaker during the scientific portion of the March 6 meeting of the Kenosha County Medical Society which was held at the Elks Club in Kenosha. Doctor Partipilo, who is professor of surgery at the Stritch School of Medicine of Loyola University, spoke on "Diagnosis and Management of Gastrointestinal Hemorrhage."

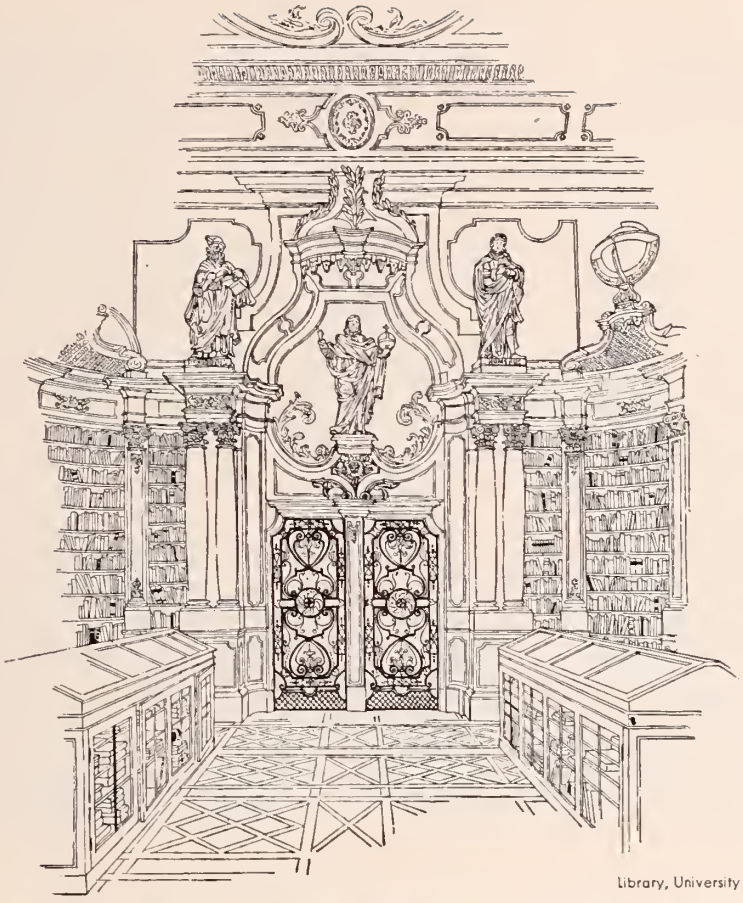
Oneida–Vilas

The members of the Oneida–Vilas County Medical Society met on March 6 to hear an address by *Dr. M. A. Krembs*, clinical instructor in obstetrics and gynecology at Marquette University School of Medicine. The title of the doctor's talk was "Hysterectomy."

Outagamie

A dinner meeting at the Elks Club in Appleton was held by the Outagamie County Medical Society on March 20. The scientific program was highlighted by a talk on "Diagnosis and Management of Coronary Disease," which was presented by *Dr. M. A. Foster* of Madison.

The Society's recently appointed committee members for 1952 are as follows:



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- Intestinal Perforation
- Peritonitis
- Soft Tissue Infection
- Ulcerative Colitis
- Vascular Infection
- Wound Infection

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Dr. J. G. Russo
Dr. W. A. Dafoe
Dr. J. E. Gmeiner
Dr. J. P. Skibba

Military & Disaster Medical Service
Dr. J. B. MacLaren
Dr. F. M. Hauch
Dr. J. J. Young

Censors
Dr. G. W. Carlson—1 year
Dr. W. A. Dafoe—2 years
Dr. R. V. Landis—3 years

Outagamie County Health Committee
Dr. J. W. Laird—1 year
Dr. H. T. Gross—2 years
Dr. L. E. Haentzschel—3 years

Auditing Committee
Dr. M. S. Kagen
Dr. M. E. Swanton
Dr. R. D. DeCock
Dr. L. R. Williams
Dr. G. A. Behnke

Trust Fund
Dr. E. N. Krueger
Dr. Simon Cherkasky
Dr. G. A. French

Program
Dr. W. S. Giffin

Note: The first named member under each committee is the chairman of that committee.

Pierce–St. Croix

Dr. E. F. Hill of Spring Valley is the new president of the Pierce–St. Croix County Medical Society. Other officers who were elected are *Dr. G. J. Hopkins*, Hudson, who will serve as vice president, and *Dr. P. H. Gutzler*, River Falls, who will hold the office of secretary-treasurer.

Price–Taylor

Meeting at the City Hall in Medford on March 1, the members of the Price–Taylor County Medical Society heard addresses by two members of the staff of the Marshfield Clinic, Marshfield. *Dr. G. S. Custer* spoke on "Newer Aspects in the Treatment of Peptic Ulcer," and *Dr. T. J. Rice* presented his paper on "Leukorrhea and its Clinical Significance."

Richland

Dr. K. E. Lemmer, associate professor of surgery at the University of Wisconsin Medical School, was the speaker during the scientific portion of the February 5 meeting of the Richland County Medical Society which was held in Richland Center at the Richland Hospital. He presented a paper on "Acute Abdominal Emergencies." A new public relations committee was established during the business session.

At the March 18 meeting of the Society, *Dr. O. S. Orth*, professor of pharmacology and anesthesiology at the University of Wisconsin Medical School, was the guest speaker. His subject on this occasion was "Pharmacological Contributions to General Practice."

Trempealeau–Jackson–Buffalo

Guest speakers at the February 21 meeting of the Trempealeau–Jackson–Buffalo County Medical Society were *Drs. P. V. Hulick* and *D. M. Buchman* of La Crosse. Meeting with the Society at the Club Midway in Independence, Doctor Hulick discussed gastric ulcers from the radiologists viewpoint and Doctor Buchman presented the internists viewpoint on the same subject.

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News Items and Personals

Parke Davis Host to Group of Wisconsin Physicians

Pictured below is a group of Wisconsin physicians who were guests of Parke, Davis and Company in Detroit on March 3 and 4. The visit was highlighted by a tour through the company's 50 year old research building—the first in America to be erected by a commercial institution solely for the purpose of scientific research. The doctors also saw operations involving the production of the antibiotic Chloromycetin.

Doctor Kores Has New Associate

On January 1, *Dr. Richard W. Way* became associated with *Dr. A. B. Kores* of Beaver Dam. A graduate of the University of Wisconsin Medical School, Doctor Way completed his internship at St. Francis Hospital in La Crosse and served a surgical residency at Mercy Hospital in Iowa City, Iowa.

Grandview Clinic Has New Staff Member

Dr. Everett Gustafson recently joined the staff of the Grandview Clinic and Hospital in La Crosse and will limit his practice to obstetrics and gynecology. The doctor is a graduate of the University of Michigan Medical School and completed his postgraduate work in his specialty under the University of Michigan program. He is a veteran of the Medical Corps of the United States Navy.

Capt. John C. McCullough Transferred Overseas

Captain John C. McCullough, former Fond du Lac physician, who has been in the Army Medical Corps since April 1951, has been transferred to Germany. He is stationed at Landstuhl with the Rhine Medical Center, 320th General Hospital. Before entering active service, Doctor McCullough was associated with the Devine Clinic in Fond du Lac.

The physicians from northeastern Wisconsin who were guests of Parke, Davis and Company in Detroit are (left to right) front row—Drs. M. H. Fuller, H. A. Aageson, G. M. La Croix, T. H. Rees, J. L. Ford, R. S. Simenson, O. W. Saunders, L. E. Rauchschwalbe, P. F. Dockry, and Mr. W. R. McNaughton; back row—Drs. C. J. Hipps, G. B. Merline, John Beck, G. M. Simon, Wallace Marshall, C. E. Wall, J. A. Killins, N. A. Bonner, W. G. Sheets, H. C. Schmalleuberg, K. L. Haman, and Mr. H. C. Booth.

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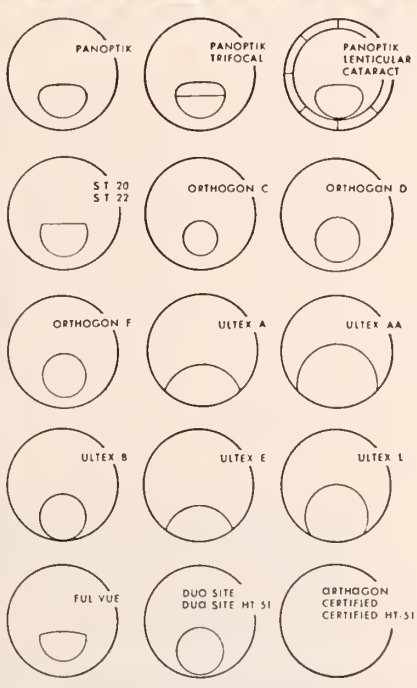

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Dr. C. A. Sattler Has New Associate

Since early in January *Dr. W. E. Braun* has been associated with *Dr. C. A. Sattler* in Kenosha in the practice of orthopedic surgery. Doctor Braun is a graduate of Marquette University School of Medicine and received his orthopedic training at Wood Veterans Hospital and at Milwaukee Children's Hospital. For the past year he had been chief of the orthopedic surgery department at the Iron Mountain, Michigan Veterans Hospital.

Doctor Sattler recently passed the examinations of the American Board of Orthopedic Surgery and has become a member of that organization.

Specialist Opens Practice in Eau Claire

Dr. Theodore W. Dasler, who was associated with *Dr. William Cornwall* of Amery from 1938 to 1941, has opened an office in Eau Claire and will specialize in ophthalmology. The doctor served in the Navy from 1941 to 1947 and upon his discharge took postgraduate work at Northwestern University Medical School. Until recently he was serving a residency at the Hines, Illinois Veterans Hospital.

Doctor Schindler Addresses Two Groups

Dr. John A. Schindler, Monroe physician, recently addressed the Walworth County Foster Parents Club in Elkhorn, as well as the Nakoma School P. T. A. in Madison. The doctor chose "Characteristics of Functional Disease" as his topic for the Elkhorn meeting, and addressed the Madison group on "The Number One Cause of Ill Health."

Dr. E. C. Cary Honored at Chicago Meeting

Dr. Erwin C. Cary, Reedsville, was honored by his election to the office of Governor of the Dale Carnegie Club International, Division Two, when the Club met in Chicago early in March. Division Two is made up of members from Wisconsin, northern Indiana and northern Illinois. Doctor Cary is also serving as 1952 president of the Wisconsin Chapter of the American Academy of General Practice.

Heart Diseases Discussed by Dr. A. M. Hutter

Dr. A. M. Hutter of Fond du Lac, past president of the Wisconsin Heart Association, addressed the Fond du Lac Lions Club at the March 5 meeting of that organization. Doctor Hutter discussed the symptoms of high blood pressure and the ways and means available to combat it. He also showed a film entitled "Guard Your Heart." On March 11, Doctor Hutter addressed the members of the Elks Club in Appleton. His subject on this occasion was "Coronary Heart Disease and High Blood Pressure."

Wisconsin Representatives Attend Conference

Dr. R. L. MacCornack, Whitehall, was the official representative of the State Medical Society at the National Rural Health Conference which was held in Denver, Colo., from February 28 to March 1. Other Wisconsinites who attended the conference were *Drs. E. E. Bertolaet*, Elkhorn, and *R. C. Parkin*, Madison; and Mr. Roy T. Ragatz, assistant secretary of the State Society, and Miss Edith Bangham of the University of Wisconsin College of Agriculture.

Dr. Roy Hong Addresses Nurses Group

Dr. Roy Hong of Wild Rose, president of the Green Lake–Waushara County Medical Society, was the guest speaker at the March 12 meeting of the Fourteenth District Nurses Association. Addressing the nurses at the Berlin Memorial Hospital, Doctor Hong chose heart diseases as the subject for his lecture.

Dr. A. G. Johnson Attends Postgraduate Course

Dr. Allen G. Johnson, Rice Lake physician, recently attended postgraduate courses at the Cook County Graduate School of Medicine in Chicago. A graduate of the University of Minnesota Medical School, the doctor served his internship at St. Mary's Hospital, Duluth.

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THIRD AND TWELFTH DISTRICT NEWS

Madison Physicians on Program in Minneapolis

Three Madison physicians recently took part in the sectional meeting of the American College of Surgeons which was held in Minneapolis from March 24 to 26. On March 24, *Dr. H. M. Coon*, superintendent of the Wisconsin General Hospital, presided over a discussion on special problems of special hospitals, and *Dr. A. R. Curreri*, director of the tumor clinic at Wisconsin General Hospital, took part in a panel discussion on breast tumors. *Dr. E. R. Schmidt*, professor of surgery at the University of Wisconsin Medical School, presented a paper on "Surgery of the Aged" at the March 25 meeting. Among other Wisconsin physicians who attended the meeting were *Drs. J. S. Supernaw*, Madison, and *R. E. Galasinski*, Milwaukee.

Surgeon Joins Staff of Quisling Clinic

Dr. A. D. Anderson, a 1943 graduate of the University of Wisconsin Medical School, recently joined the staff of the Quisling Clinic in Madison. After receiving his medical degree, Doctor Anderson interned at the Philadelphia General Hospital and served a residency in surgery at the same hospital from 1944 to 1946. A veteran of the Army Medical Corps, the doctor entered service at the Mayo Clinic, Rochester, Minn., in October of 1948 and received his degree of master of science in surgery from that Clinic.

Doctor Tenney Serves as Moderator

Dr. H. Kent Tenney, Jr., Madison, served as moderator for the panel discussion at the annual meeting of the Dane County Child Guidance Center which was held on April 1 at the First-University Methodist Church in Madison. Others on the panel were Drs. Hertha Tarrasch, psychiatrist for the Child Guidance Centers in Rock and Jefferson Counties; *Keith M. Keane*, director of the Manitowoc and Sheboygan Child Guidance Centers, and *James A. Johnson*, psychiatrist for the Milwaukee County Guidance Clinic.

Specialist Opens Practice in Madison

Dr. J. P. McDermott, who until recently was serving a residency at the Edward Hines Veterans Hospital in Hines, Illinois, has opened an office in Madison for the practice of general surgery. The doctor is a graduate of the Northwestern University Medical School and interned at the Cook County Hospital in Chicago. Prior to entering the medical corps of the Navy, he was a resident surgeon at the University Hospital, Chicago.

Doctor Jackson Addresses Alabama Meeting

Dr. Arnold S. Jackson of the Jackson Clinic, Madison, addressed the February regional meeting of the American Chapter of the International College of Surgeons which was held in Birmingham, Alabama. Doctor Jackson is secretary of the organization.

Lecture on Medical History Presented

Dr. Erwin H. Ackerknecht, professor of history of medicine at the University of Wisconsin Medical School, was the guest speaker for the ninth annual D. J. Davis Lecture on Medical History which was presented on April 9 at the University of Illinois College of Medicine. The title of Doctor Ackerknecht's address was "Diseases in the Middle West."

Dr. T. O. Nuzum Addresses Janesville Meeting

"You and Your Heart—A Subject of Vital Interest Both on and Off the Job" was the topic discussed by *Dr. Thomas O. Nuzum,* Janesville, at the March 5 meeting of the Janesville Safety Council. Doctor Nuzum conducted a question and answer period and showed a related film, "Guard Your Heart."

Rock

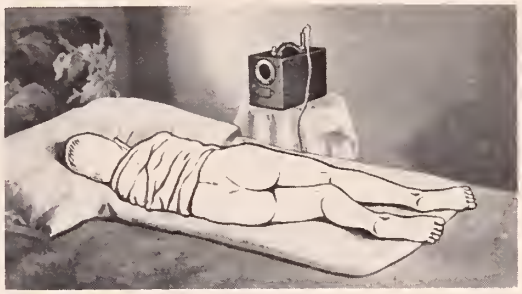
Dr. James H. DeWeerd of the Mayo Clinic was the guest speaker at the March 25 meeting of the Rock County Medical Society which was held at the Beloit Country Club. Doctor De Weerd addressed the members of the Society on the "Surgical Approaches to the Lower Ureter and Bladder."

Medical School Society of the University of Wisconsin

"Where Do Viruses Come From?" was the subject of an address by Dr. Richard E. Shope at the March 18 meeting of the Medical School Society of the University of Wisconsin held jointly with the Department of Veterinary Science. Doctor Shope is a member of the Rockefeller Institute for Medical Research.

U. W. Society Sponsors Lecture

Alpha Epsilon Iota of the University of Wisconsin Medical School, fraternity of medical women students, presented the Katharine Baird Memorial Lectureship on March 27 at the auditorium of the Service Memorial Institute building. Dr. Flanders Dunbar, assistant physician at the Presbyterian Hospital and Vanderbilt Clinic in New York City, addressed the group on "Psychosomatic Medicine."



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Dr. F. D. Murphy Honored

F. D. MURPHY, M. D.

Dr. F. D. Murphy, clinical professor and director of the department of medicine of Marquette University, received the annual medical alumni award from Marquette University on March 29. The award, which was presented by Father A. F. Berens, S. J., medical school regent, was given during the annual spring clinic for medical alumni. Doctor Murphy presented a talk at the meeting on "Changing Aspects of Medicine in My 30 Years of Practice."

Milwaukee Physician Accepts Post in Racine

Dr. Harold Schroeder of Milwaukee, former child psychiatrist for the Waukesha County Welfare Department, recently resigned from that post to take a full time position with the Racine Guidance Clinic. Dr. Owen Otto, also of Milwaukee, was appointed to the vacancy in Waukesha County.

Dr. I. I. Cowan Addresses Medical Librarians

Dr. Irving I. Cowan, assistant professor of radiology at Marquette University, addressed the annual meeting of the Wisconsin Association of Medical Record Librarians which was held at the Hotel Schroeder in Milwaukee on March 17. Doctor Cowan chose "Radioactive Isotopes" as the subject of his lecture.

Milwaukee Academy of Medicine

"The Role of Arterial Transfusion in Profound Shock" was the subject of an address by Brigadier General S. F. Seeley at the March meeting of the Milwaukee Academy of Medicine. Doctor Seeley is chief of the surgical service at Walter Reed Army Hospital.

Milwaukee Neuro-Psychiatric Society

The regular monthly meeting of the Milwaukee Neuro-Psychiatric Society was held at the University Club in Milwaukee on March 19. The scientific program was presented by *Drs. David Cleveland* and *Edward Kiefer* who spoke on "The Management of Intractable Pain."

SOCIETY RECORDS

New Members

F. P. Krumenacher, 3321 North Maryland Avenue, Milwaukee.

V. M. Bernhard, 7769 North Club Circle, Milwaukee.

Jane Jameson, Indiana University Center, Indianapolis, Indiana.

E. E. Lebow, 3023 North 53rd Street, Milwaukee.

J. T. Majewski, 425 East Wisconsin Avenue, Milwaukee.

D. J. Albrecht, 4720 West Montrose Avenue, Milwaukee.

Changes in Address

Erich Wisiol, Stevens Point, to 2713 N. E. Fifteenth Street, Fort Lauderdale, Florida.

J. A. Schelble, Milwaukee, to R. R. One, Hartland.

F. G. Slattery, Wild Rose, to Wautoma.

Elvira C. Seno, Ft. Lewis, Washington, to U. S. Army Hospital, Camp Carson, Colorado.

R. C. Mathewson, Boston, Massachusetts, to 4530 Duplessis Street, New Orleans, Louisiana.

J. F. Carney, Camp Pickett, Virginia, to 1007 Elmhurst Avenue, Peoria, Illinois.

E. J. Collier, Madison, to 2948 Ivanhoe, Denver, Colorado.

Louis Kagen, New York, to 536 West Wisconsin Avenue, Milwaukee.

D. P. Davis, New York, to 1812 Prospect Avenue, Erie, Pennsylvania. (Military service member, mailing address only.)

N. S. Davis, Sturgeon Bay, to 2200 McDaniel Street, Evanston, Illinois.

L. H. Lokvam, Stevens Point, to 7115 Third Avenue, Kenosha.

C. C. Peterson, River Falls, to Suite 301, Crees Building, Corvallis, Oregon.

M. E. Sattler, Milwaukee, to 3320 Medical Square, Amarillo Air Force Base, Amarillo, Texas.

A. A. Bullock, Jr., Milwaukee, to Veterans Administration, Wood.

J. C. Moore, Madison, to 134 South Barrington Avenue, Brentwood Village, Los Angeles 49, California.

DEATHS

Dr. George W. Ison, Crandon physician for 37 years, died suddenly at his home on February 13, 1952. He was 65 years old.

Born in Burke, Kentucky, the doctor graduated from the University of Louisville School of Medicine in 1913 and established his practice in Crandon in 1915. Active in civic affairs of his community, Doctor Ison had served as city health officer, as a member of the Forest County Board of Supervisors, and also as a member of the local school board. He was a member of the staff of St. Mary's Hospital, Rhinelander.

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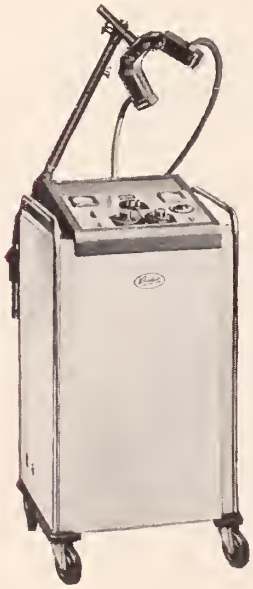

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His professional affiliations included membership in the Forest County Medical Society, the State Medical Society, and the American Medical Association.

Surviving are his wife, a son, and a daughter.

Dr. Richard Jandrain, a Luxemburg physician for the past 20 years, died in a Green Bay hospital on February 19, following a short illness. He was 55 years old.

Born in the town of Walhain on May 24, 1896, the doctor received his medical degree from Marquette University School of Medicine in 1927. He practiced in Abbotsford for a short time before moving to Luxemburg.

Survivors include three daughters and two sons.

Dr. Irwin E. Bowing, Kenosha radiologist, died at his home on February 24, after a short illness. He was 59 years old.

Born in St. Cloud, Minn., on July 4, 1892, the doctor graduated from the University of Chicago and received his medical training at Rush Medical College, Chicago. Following his graduation in 1921, he practiced in St. Cloud until 1925 when he moved to Kenosha.

For many years he was radiologist for the Kenosha Hospital, St. Catherine's Hospital, and Willowbrook Sanitorium. During World War II he served on the Medical Advisory Board of Selective Service.

Doctor Bowing was a Fellow of the American College of Radiology and also held membership in the Radiological Society of North America, the Chicago Roentgen Society, the Kenosha County Medical Society, the State Medical Society and the American Medical Association.

He is survived by his wife and two daughters.

A. A. SCHAEFER

Dr. Arthur A. Schaefer, 48, Milwaukee surgeon, died on March 3 at his home. He was born in Milwaukee on October 13, 1902.

A graduate of the University of Wisconsin, the doctor received his medical degree from Harvard Medical School in 1928. He returned to Milwaukee for his internship and residency, serving them at Columbia and Children's Hospitals. He began his practice of surgery in his native city in 1931.

He was an associate clinical professor of surgery at the Marquette University School of Medicine and a member of the staffs of Columbia and Children's Hospitals. He was chief of the surgical staff at Children's Hospital until a year ago, when he took a leave of absence.

A diplomate of the American Board of Surgery, Doctor Schaefer was vice-president of the Milwaukee Academy of Medicine and a past president of the Milwaukee Surgical Society. He was a fellow of the American College of Surgeons and a member of the Wisconsin and the Central and Western Surgical Societies. He also held membership in the Medical Society of Milwaukee County, the State Medical Society, and the American Medical Association.

He is survived by two sons, a sister, and a brother.

Dr. Louis T. Baehr, 34, resident surgeon at Wisconsin General Hospital, Madison, died suddenly on March 4 at his home. He was born in Berlin on January 30, 1918.

A 1943 graduate of the University of Wisconsin Medical School, the doctor served his internship at Kansas City Research Hospital. Upon completion of his contract, he entered the Army Medical Corps and served overseas until 1946. He practiced in Janesville, associated with the Munn–Koch Clinic, from 1946 to 1948 and then began a residency in surgery at Wisconsin General Hospital.

Survivors include his wife and two daughters.

Dr. Miles D. Cottingham, 70, retired Kohler physician, died March 12. He was born January 25, 1882 at Benton.

The doctor was a graduate of Marquette University School of Medicine, and also took additional training at the New York Post Graduate Hospital during 1912 and 1913. Following this training, he became associated with the Illinois Central Railroad, serving as chief surgeon at the Galena, Illinois office. He later moved to Lake Geneva to enter private practice. After serving in the Army Medical Corps during World War I, Doctor Cottingham practiced in Milwaukee for a short time before moving to Kohler. At the time of his retirement in 1949, he was director of the Kohler Company medical department.

He is survived by his wife.

Dr. Lillie Rosa Minoka–Hill, Oneida, one of the two Indian women physicians in the United States, died on March 18 in a Fond du Lac hospital. She was born in the state of New Jersey on August 30, 1876.

An 1899 graduate of the Woman's Medical College of Pennsylvania, the doctor served her internship at Woman's Hospital, Philadelphia. While practicing in Philadelphia, she married Charles Hill, a full-blooded Oneida Indian. She and her husband returned to his home on the Oneida reservation, where she devoted herself to her family. In 1934 she received a license to practice medicine in Wisconsin and became an active practitioner.

A Mohawk Indian by birth, Doctor Hill was adopted by the Oneidas on Thanksgiving Day, 1947, and given the fitting name of "Youdagent," which means "she who serves." She received national rec-

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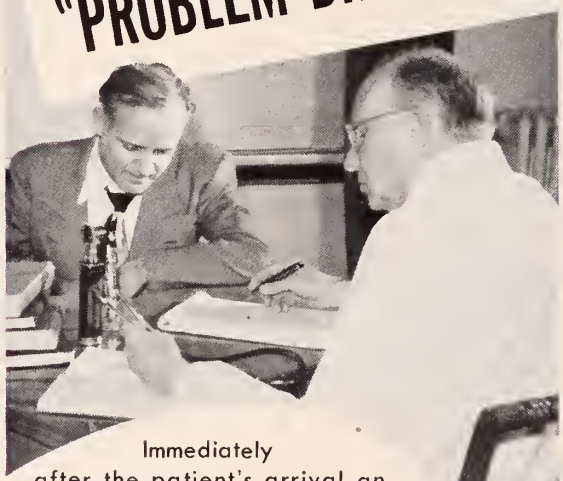

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ognition in 1947 when she was named "the outstanding American Indian of the year" by the Indian Council Fire in Chicago. The agriculture department of the University of Wisconsin honored her in 1949 when she was selected as one of two women to receive a certificate for outstanding service to rural people. This citation read in part, "inspiring homemaker and mother, untiring builder of health, unselfish servant of the public, and deserving bearer of the tribal title, 'She Who Serves.'"

In 1949, Doctor Hill was made an honorary member of the Outagamie County Medical Society and of the State Medical Society. She was the guest of the societies at the American Medical Association convention of that year and also at the fiftieth reunion of her medical school class at Philadelphia. She is survived by three sons and two daughters.

Dr. Harry J. McLaughlin, Bloomington physician, died March 19 in a Lancaster hospital. He was 75 years old.

Born near Seneca on April 28, 1876, the doctor graduated from the St. Louis College of Physicians and Surgeons and interned at the Jefferson Hospital in St. Louis. He established his practice in Bloomington in 1916 and was active in that city until his retirement in December of 1950.

In September 1951, the residents of Bloomington and the surrounding area gathered to honor the doctor for a "Doc Mac Day" celebration. The festivities featured a parade in which 600 of his 4,144 "babies" marched.

He is survived by a son.

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Address as follows: Medical Library Service, Service Memorial Institute Building, North Charter Street, Madison, Wisconsin.

Doctor Come Quickly. By Frank J. Clancy, M. D., Seattle, Superior Publishing Company, 1950. Price $2.95.

"Doctor Come Quickly" is a thoroughly entertaining and somewhat unusual medical novel, which like many other medical novels serves as an autobiography of the person who wrote it. This one, however, is written in turnabout fashion; that is, the doctor relives his medical experiences through telling the reader about the more interesting patients with whom he has come in contact and about his successes and failures in the treatment of these people.

Even if only the preface had been written, "Doctor Come Quickly" would be in my opinion a success. The easy editorial and completely unsarcastic style with which the writer "takes apart" most "doctor stories" in the preface is indeed masterful. His description of the difference between the doctor in fictional medicine, whom he describes as "a mixture of leading man, poet, lover, and magician," and the doctor in real life will be recognized by fellow physicians as being entirely accurate in the great majority of cases and should provide lay readers with a more accurate conception than the one currently popular, which seems to be that of a wealthy, nondeserving gouger.

The body of the novel deserts the usual chronological pattern only once, in that several chapters in the beginning of the book describe Doctor Clancy's early experiences as a practicing physician, after which he resorts to the flashback and describes briefly and without laboring the point his earlier life including his medical education and experiences in World War I. The doctor is extremely skillful in tying together what would otherwise be a series of loose anecdotes concerning the various patients he has treated so that they fall into an entirely coherent and understandable pattern, giving us a more or less birdseye view of his practice through the years. He takes up the doctor-patient relationship from many angles which are ordinarily not considered as important either to doctors or laymen—from the angle, for instance, of the doctor's colleague whom he may call into consultation; from the angle of the patient's relatives who react in a number of different ways to the fact of the patient's hospitalization and need for surgery. Doctor Clancy eventually chooses the field of urology as his specialty and as a specialist becomes fully accepted in the field of consultant practice in the city of Seattle.

He ends his novel with several chapters of what might be considered a type of homespun philosophy. While these are a bit less chatty than the rest of the novel, they do not in my opinion detract in any way from the entertainment value of the book.

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Vasoconstriction — to which the visual prodromata are attributable. It is possible to abort the attack during this phase in all but a few cases. (See treatment below.)

Vasodilatation — as the vessels lose their tone, exaggerated pulsations set in, resulting in the throbbing pain which characterizes vascular headache. Treatment for the attack is still effective during this phase. (See below.)

Vessel Edema — if the vasodilation continues for too long, vessel walls become edematous; this changes the character of the pain to a steady, intense aching. The attack can now no longer be checked, even with maximum dosage of specific drugs. *Moreover, sustained headache often induces reflex neck muscle tension, a source of residual pain.*

Therapy: 1. Reduce the frequency of attacks — psychotherapy and regulation of living habits to avoid fatigue and nervous tension.

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GENERAL REFERENCES: DeJong, R.: Chicago M. Soc. Bull *54:* 106, 1951. Friedman, A.: Modern Headache Therapy, St. Louis, C. V. Mosby Co., 1951. Wolff, H.: Headache and Other Head Pain, N. Y., Oxford Univ. Press, 1948.

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I can sincerely recommend "Doctor Come Quickly" as an interesting evening's light reading, both for members of the medical profession and for the laity.—R.C.P.

Progress in Gynecology. Edited by Joe V. Meigs, M. D., Clinical Professor of Gynecology, Harvard Medical School; Chief of Staff of the Vincent Memorial Hospital, the Gynecological Service of the Massachusetts General Hospital; Surgeon, Pondville Hospital; Gynecologist, Palmer Memorial Hospital; and Somers H. Sturgis, M. D., Clinical Associate in Gynecology, Harvard Medical School; Assistant Surgeon, Massachusetts General Hospital, Boston, Massachusetts. Volume II. New York, Grune and Stratton, 1950.

As was true of the first volume of Progress in Gynecology, this is a collection of reports on various phases of gynecologic diagnosis and technic. Many of the leading gynecologists in this country and some from England and Europe have contributed to the volume. Each contributor was asked to write on his "hobby," which has permitted a certain amount of repetition in the text. Chapters that were included in Volume One where there has been little recent progress, have not been included in this volume. All those chapters carried over into Volume II have been reviewed and revised.

Ten major sections are included in this volume: (1) Growth and Physiology, (2) Diagnostic Methods, (3) Functional Disorders, (4) Interrelationship of Endocrine Glands, (5) Sterility and Reproduction, (6) Infections and their Treatment, (7) Benign Growths, (8) Malignant Growths, (9) Operative Technique, and (10) Preoperative and Postoperative Care.

The book presents a good review of current methods of diagnosis and treatment in Gynecology. It is a valuable reference volume for residents in gynecology, practicing gynecologists and the general practitioner.—M.J.T.

Questions and Answers, Volume 3. Edited and Compiled under the supervision of J. F. Hammond, M. D., Associate Editor, The Journal of the American Medical Association, Chicago, Illinois. Pp. 517. Chicago: American Medical Association, 1950.

This volume contains a heterogeneous collection of queries and answers selected from the well-known department in the Journal of the American Medical Association. These notes contain a great wealth of information which is ordinarily located only with considerable difficulty, and a little time skimming through the volume will probably repay the average practitioner many times over for his efforts. The information given for the most part represents the best available opinion or information about the subjects, although in a number of instances one notes that rather definite statements are made about subjects that are somewhat controversial. It is unfortunate that the source of information is not more frequently cited or a wider use made of references to the literature, since the limited space alloted to the individual queries leaves many questions unanswered. The material is grouped under roughly related categories such as blood tests and blood diseases, drugs and drug

poisoning, hair and nails, heredity, etc., but even with this aid, locating specific information within the text would be difficult and the absence of an adequate index would appear to be a major defect. Kept at hand for an idle moment or bedside reading, however, the book would represent an interesting and valuable addition to almost any practitioner's library.—J.L.S.

Primer on Fractures. Prepared by the Special Exhibit Committee on Fractures in cooperation with the Committee on Scientific Exhibit of the American Medical Association. Sixth edition. New York, Paul B. Hoeber, Inc., Medical Book Department of Harper and Brothers, 1951. Price $2.00.

This book is prepared by the Committee on Fractures in cooperation with the Committee on Scientific Exhibit of the American Medical Association. The book is written in an endeavor to meet the needs of the general practitioner who sees the fracture first. Simplification of methods of treatment and an approach to the problem of fractures from the standpoint of anatomy and physiology such that the general practitioner can handle most of the common types of fractures skillfully and successfully is presented. Operative treatment of fractures is mentioned only in certain fractures which indicate operative procedures which may be used only by those who are skilled in bone surgery.

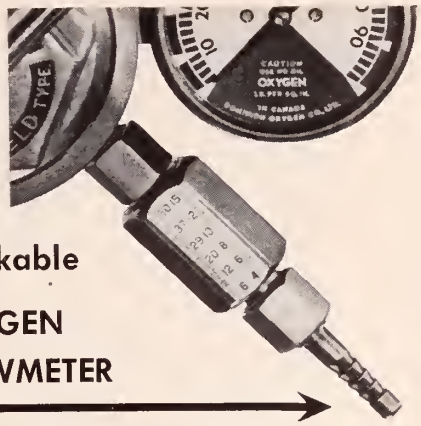
This is a valuable little book for the general practitioner.—H.W.W.

The 1950 Year Book of Drug Therapy. Edited by Harry Beckman, M. D., Director, Department of Pharmacology, Marquette University School of Medicine. Chicago, The Year Book Publishers, Inc., 1951. Price $5.00.

Therapeutic advances have been so rapid and varied during the past decade that frequent expressions of despair are heard at keeping pace with them in modern medical practice. This Year Book, the second under the authorship of this well recognized authority, is designed to make possible such an effort, and in the minimum of time. The book contains much pertinent information of value to the general practitioner or specialists in every field. To me, its possession would seem practically a *must* for any licensed physician.

A special introductory article "Advances in Drug Therapy During 1940–1950" is very unique, worth while, and even to those who consider that they have maintained pace with therapeutic advancement in the past ten years it will contain some very startling bits of knowledge. In this 15 page review is stated in a very succinct manner the principal progress made for each of the sections into which the literature of October 1949 to September 1950 is classified.

The final l'envoi raises the very pertinent question as to the value which will accrue to mankind in the principal conquest which has been made of infectious disease. As the author states: "We have saved hordes of people who would otherwise be dead, but we are obtuse indeed if we expect gratitude from



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the youthful majority of the world whom this act will eventually engulf in economic desperation. We physicians must make it known that the aging and the aged we are keeping alive are not wrecks, incapable of carrying at least a part of the burden of their support. We must devise industries in which older persons can work, else children will fling their parents to the State, and to be old will be horrible. We must convince political leaders that without assuring the *productive* existence of the elderly, their vaunted economic security is no more than a shibboleth. We doctors must do this." The challenge is a great one to the medical profession—since it has been predominantly instrumental in its creation! —O. S. O.

Handbook of Pediatric Medical Emergencies. By Adolph G. DeSanctis, M. D., professor of pediatrics and chairman of the department of pediatrics, Post-Graduate Medical School, New York University–Bellevue Medical Center; director of pediatrics, University Hospital, New York University–Bellevue Medical Center; director of pediatrics, Gouverneur Hospital, New York City; and Charles Varga, M. D., instructor in pediatrics, Post-Graduate Medical School, New York University–Bellevue Medical Center; assistant attending pediatrician, University Hospital, New York University–Bellevue Medical Center; assistant visiting pediatrician, Gouverneur Hospital, New York City. Pp. 288, with 51 illustrations. St. Louis, The C. V. Mosby Company, 1951. Price $5.00.

The authors have combined their own experiences and those of authorities in various fields to produce an excellent short textbook on the diagnosis and treatment of emergencies encountered in practice with infants and children.

Clear, concise discussions of such topics as cardiovascular, gastrointestinal, genito-urinary, neurologic and respiratory emergencies are presented.

The book includes chapters on the care of the premature infant, drowning, and poisoning. Unique in texts of this kind is an appendix giving the trade names of most of the common household remedies, cleaning fluids, rodenticides, etc. and the poisonous substances which they contain.

A fine chapter on pediatric procedures completes a handbook which the reviewer regards as the best he has encountered on the subject.—K.B.M.

The Prostate Gland. By Herbert R. Kenyon, M. D., associate clinical professor, department of urology, New York University, Bellevue Medical Center. New York, Random House, 1950. Price $2.95.

This book is a well authenticated presentation of the illnesses which may befall the human prostate gland. The text is brief but contains the essence of current knowledge of physiology and diseases of the prostate. Although some details may be beyond the background of the average non-professional reader, the book is an excellent reference for the intelligent person interested in a commonly disordered and often misunderstood gland.

With recent emphasis upon gerontology, Doctor Kenyon's book deserves the serious consideration of those interested in sociology, economics, and culture, since oftimes a momentous worldwide decision may depend upon the whim of a diplomat with prostatic disease.

The chapter on benign hypertrophic obstruction and discussion of various surgical treatments is particularly complete. Mortality and morbidity statistics indicate the great progress which has been made in reduction of mortality from 20 to 40 per cent in 1920 to the current 2 to 4 per cent. Simple principles of technic with complications and sequelae are described with impartiality towards any particular method.

"The Challenge of Prostatic Cancer" chapter is particularly written to focus attention upon the male half of our ageing population which has been neglected from the standpoint of periodic prophylactic medical examination of this prevalent cancer site.—I. I. K.

Practical Clinical Psychiatry. By Edward A. Strecker, A. B., A. M., Sc. D., Litt. D., LL. D., M. D., professor of psychiatry, School of Medicine, University of Pennsylvania; Franklin G. Ebaugh, A. B., M. D., professor of psychiatry, University of Colorado, School of Medicine, Director, Colorado Psychopathic Hospital; Jack R. Ewalt, M. D., professor of neuro-psychiatry, administrator of hospitals, University of Texas Medical Branch, Galveston, Texas. Seventh edition. New York, Toronto, Philadelphia, The Blakiston Company, 1951. Price $7.00.

This well known primer in psychiatry by former students of Adolf Meyer now undergoes its seventh revision. The content is directed primarily toward medical students, general practitioners, and specialists in other areas of medicine who feel the need for a basic grounding in psychopathology. The book succeeds admirably in this intent, particularly in its excellent chapter on "support psychotherapy." Of particular value too are the chapters on the organic reaction type and toxic psychoses, both reactions which the general practitioner encounters often, particularly with the increased proportion of the aged in our population.

However, the reader should be warned that certain subjects are dealt with inadequately in this text. This is the case in the chapter on "The Constitutional Psychopathic Inferior," and the reader would be advised to supplement this material with the chapter on the same subject by Preu in Hunt's "Personality and the Behavior Disorders." Mental defect is also inadequately treated, as is also the subject of alcoholism. Comparatively speaking all of these areas constitute peripheral areas of interest, however, and these are not serious deficiencies. In a book with as broad a scope as this, some topics must be superficially covered.

In the most important and frequently occurring syndromes—schizophrenia, manic-depressive reactions and the psychoneuroses—this book provides good basic information. For the most part it has clarity, cohesiveness, and authoritative discussion. The frame of reference is broad, inclusive, carefully documented and, in areas at issue, undogmatic.—R. R.

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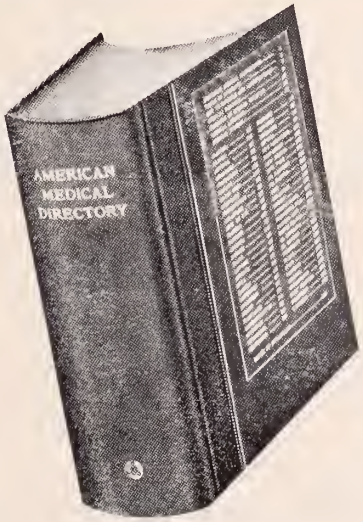

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FOR SALE: Office equipment, medical library and instruments of deceased physician. All in excellent condition. Write Mrs. E. Panetti, Hustisford, Wisconsin.

FOR SALE: Maico Audiometer D.C., 2 sets of laryngoscopes, and phoroptor stand. Address replies to No. 412 in care of the Journal.

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FOR SALE: General Electric portable shockproof x-ray unit, $100; slightly used Krazno–Ivy Flicker Photometer for detection of early cardiovascular disease, $165; several Jones basal metabolism units, factory re-conditioned and guaranteed to be accurate and in good mechanical condition, $125. Address replies to C. C. Remington, 1204 W. Walnut St., Milwaukee 5, Wis. Phones, Locust 2–8118 and Woodruff 2–4028.

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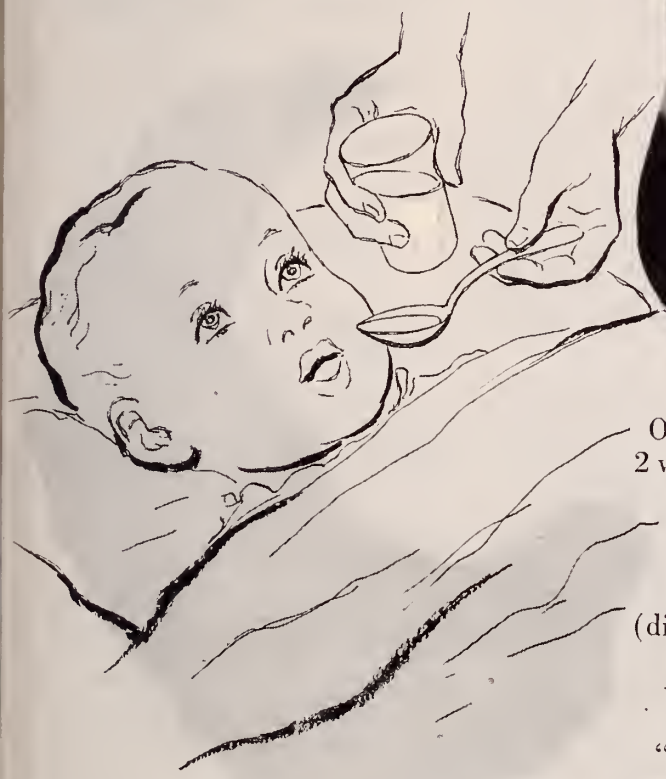

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Calumet	E. P. Larme New Holstein	L. W. Keller Brillion	
Chippewa	C. T. Clauson Bloomer	B. F. Rahn Cadott	
Clark	K. F. Manz Neillsville	G. G. Shields Abbotsford	
Columbia-Marquette-Adams	R. F. Inman Montello	E. G. Nafziger Oxford	Second Tuesday 7:00 p.m.
Crawford	O. E. Satter Prairie du Chien	H. L. Shapiro Prairie du Chien	
Dane	G. H. Ewell Jackson Clinic Madison	G. C. Hank 110 E. Main Madison	Second Tuesday
Dodge	C. L. Qualls Beaver Dam	R. E. Urbanek Beaver Dam	
Douglas	C. T. Droege 1507 Tower Superior	R. T. Anderson 1507 Tower Superior	First Wednesday** Badger Room of the Hotel Superior
Eau Claire-Dunn-Pepin	W. G. Cameron 131 S. Barstow Eau Claire	H. E. Sorensen 314 E. Grand Eau Claire	Last Monday
Fond du Lac	R. W. Steube St. Agnes Hospital Fond du Lac	N. O. Becker 104 S. Main Fond du Lac	Fourth Thursday*
Forest	O. S. Tenley Wabeno	B. S. Rathert Crandon	
Grant	N. G. Rasmussen Montfort	H. W. Carey Lancaster	Last Thursday, March, June, Sept. and Nov.
Green	W. B. Gnagi Insurance Bldg. Monroe	L. G. Kindschi Monroe Clinic Monroe	
Green Lake-Waushara	Roy Hong Wild Rose	R. S. Pelton Markesan	Last Thursday, every other month starting in Jan.

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COUNTY	PRESIDENT	SECRETARY	MEETING DATE
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Jefferson	E. A. Miller 133 Riverlawn Watertown	E. J. Netzow Lake Mills	
Juneau	J. S. Hess Mauston		Second Tuesday Hess Clinic in Mauston
Kenosha	H. L. Schwartz 625 57th Kenosha	Helen A. Binnie 7609 25th Kenosha	First Thursday* Elks Club Kenosha
La Crosse	J. J. Satory 1707 Main La Crosse	D. M. Buchman 308 Newburg Bldg. La Crosse	Third Monday
Lafayette	D. J. Garland Shullsburg	N. A. McGreane Darlington	
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Lincoln	L. J. Bayer Merrill	J. D. Millenbah Merrill	
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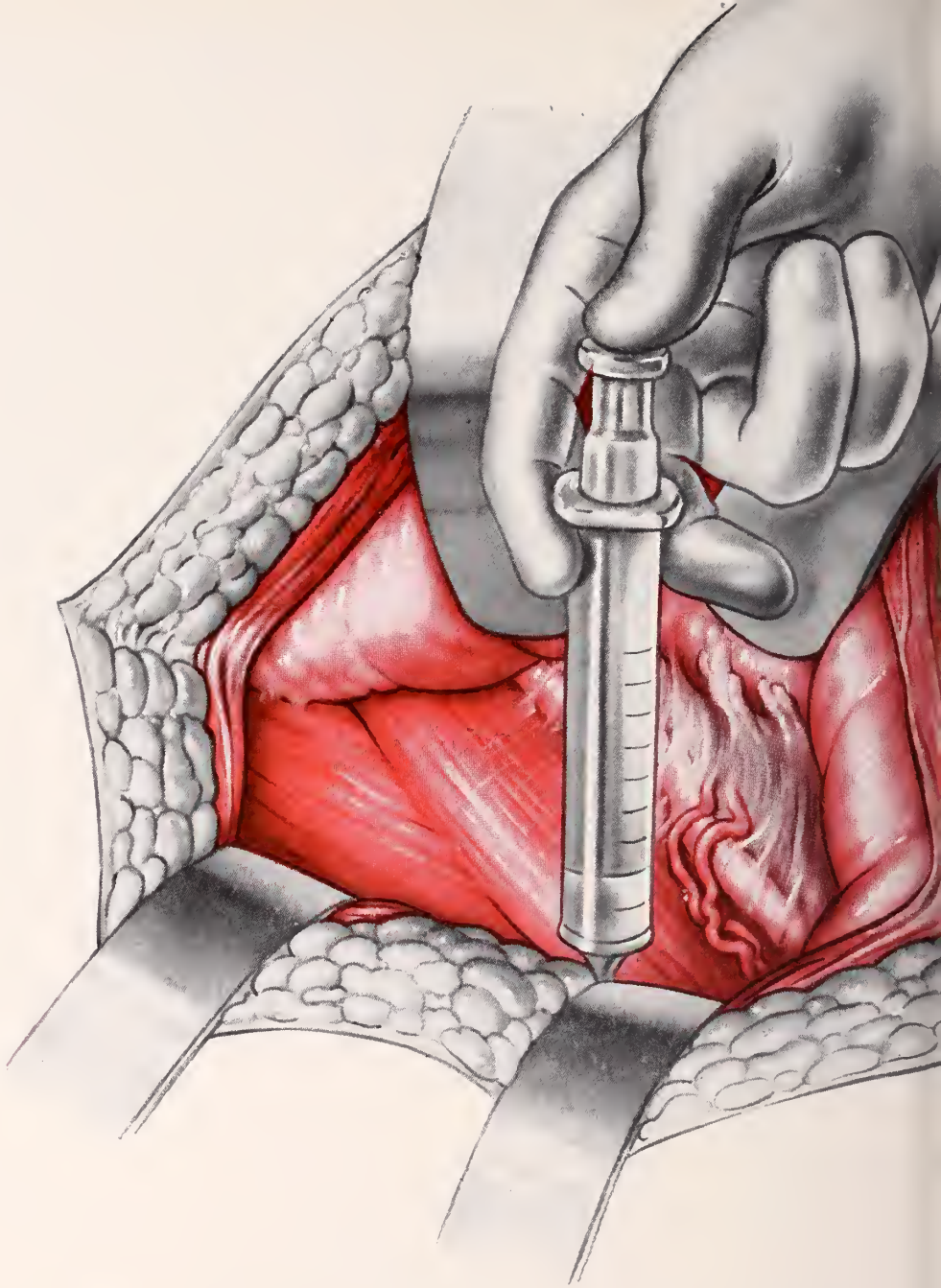

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Sprague, R. G.: Cortisone and ACTH, Am. J. Med. *10*:567, 1951.

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Contrary to the former belief that serum cholesterol levels are primarily related to ingested animal fat and consequently to dietary cholesterol, it now appears that the total amount of fat in the diet, not its source or cholesterol content, is a more important factor in determining the blood cholesterol concentration.[1,2,3,4] Clinical observation has shown that ingestion of vegetable fat—which contains no cholesterol—will, like fats of animal origin, raise the serum cholesterol level.[3, 5]

Recent basic research on the influence of fats and cholesterol on human health has done much to further progress in the fight against atherosclerosis. It will serve well in dispelling the mistaken fear that reasonable amounts of foods of animal origin predispose the individual to this vascular disease.[6] As a matter of fact, a dietary inadequate in essential nutrients but providing too many calories and too much fat from *any* source may well be an important factor underlying the deposition of fat and cholesterol in the arteries and liver.

Cumulative evidence indicates that lowered blood levels of cholesterol may be effected by restricting the total fat intake.[1] Except in instances of refractory hypercholesteremia, in which a daily fat intake as low as 10 Gm. may not reduce cholesterol levels to normal, diets containing 20 to 30 Gm. of fat, or even more, often produce low cholesterol blood levels. In the clinical application of this principle, various palatable, low fat diets which supply three servings of meat daily (containing 18 Gm. of fat) have recently been suggested for the dietary management of arteriosclerosis and for enlisting the cooperation of patients.[1] The meat servings were chosen from a large variety of cuts and kinds of meat (fat trimmed off, as lean as possible). Meat adds to the eating appeal of the fat-restricted diet and contributes important amounts of biologically complete protein, the B group of vitamins including B_{12}, and food iron—all of which are important for a good state of nutrition in the atherosclerotic patient.

1. Hildreth, E.A.; Hildreth, D.M., and Mellinkoff, S.M.: Principles of a Low Fat Diet, Circulation *4*:899 (Dec.) 1951.
2. Bloch, K.: The Intermediary Metabolism of Cholesterol, Circulation *1*:214 (Feb.) 1950.
3. Keys, A.; Mickelson, O.; Miller, E.V.O., and Chapman, L.B.: The Relation in Man Between Cholesterol Levels in the Diet and in the Blood, Science *112*:79, 1950.
4. Gubner, R., and Ungerleider, H.E.: Arteriosclerosis, a Statement of the Problem, Am. J. Med. *6*:60, 1949.
5. Hildreth, E.A.; Mellinkoff, S.M.; Blair, G.W., and Hildreth, D.M.: The Effect of Vegetable Fat Ingestion on Human Serum Cholesterol Concentration, Circulation *3*:641 (May) 1951.
6. King, C.G.: Trends in the Science of Food and Its Relation to Life and Health, Nutrition Rev. *10*:1 (Jan.) 1952.

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*Matthews, J. G.: Care and Healing of Traumatic Wounds. *Northwest Med.*, 50:512, July, 1951

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1. Silbert, N. E.: New England J. Med. *242*:931, 1950.
2. Eisenstadt, W. S.: Journal Lancet *70*:26. 1950.

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Blahey, P. R.: Canad. M.A.J. 66:151 (Feb.) 1952.

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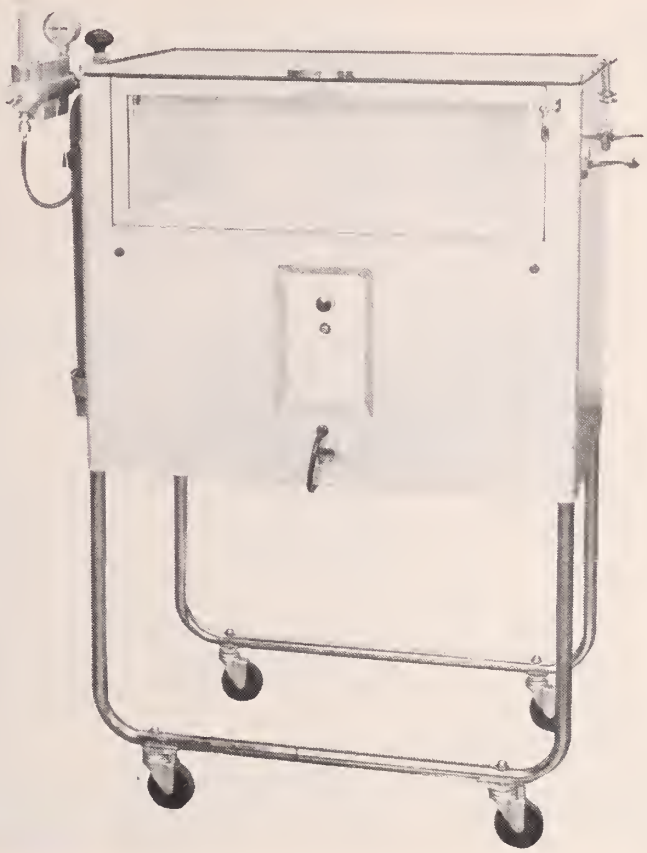

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Principles, Not Personalities

The 1952 Presidential campaign gathers steam with each passing day. In the excitement about favorite sons, "dark horses," and popularity polls, it is easy to be distracted from the significant issues of our day. Who is elected is important. But of even greater importance is the one basic issue:

Do we want our government to be the servant of the people? Or do we want it to be master over us?

Should we allow the Federal government in Washington to acquire more and more power. Or should we stand pat on the principles of our Constitution which specified that any powers not expressly given to federal officials were to remain with the individual citizens and their local governments?

Shall we permit Federal officeholders to install a system of compulsory, government-guaranteed "security?" Or shall we insist that personal responsibility for one's own welfare brings increased material well-being—a principle that America has proved to be the most effective that the world has ever known in the field of government.

Do we want taxes to go up and up, taking away from the wage-earner more and more of the fruits of his labor? Do we want corruption to continue destroying the people's faith in their public officials? Do we want inflation to so completely destroy the value of our medium of exchange that it is hardly safe to be thrifty?

Do we want the Federal government to have such gross misconceptions of its "duty" that it completely separates the physician from his patient and subjects both to its advice and control regarding the care of the sick?

Shall our America be the land of opportunity, of individual freedom, of personal responsibility, or should this be merely a land of uneasy, forced security?

These are part and parcel of the fundamental issues in America today. These issues remain regardless of the individual or party in power. Experience has shown us that the growth of Government in any field, once started, usually goes forward regardless of the party in power or the amount of resistance.

We know that the election or appointment of a man to public office does not endow him with wisdom or compassion. It can only endow him with power. It is this power that creates welfare states, socialist states, and dictatorships, not who is elected or how he is elected.

Unless we put the government back into the place assigned it by our ancestors as a servant of the people, we will miss the greatest opportunity of the coming election.

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How Valuable Are Industrial Health Clinics?

These are days when many doctors are experiencing "meeting fatigue." Because of Wisconsin weather the months of April and May are unusually filled with conferences, meetings, and conventions which doctors are expected to attend. Therefore, it is fitting every now and then to pull out the microscope of critical inquiry and see if what we are doing is really worth while, or whether it is being kept alive out of habit or organizational reflex movement.

At a recent Industrial Health Clinic a guest speaker from another state became all excited about the type of meeting we have been conducting in Wisconsin for many years. He felt we had hit upon a revolutionary idea, but to Wisconsin physicians and industrial health nurses the annual in-plant clinics have become institutions.

Looking back on our 1952 Industrial Health Clinics we are again impressed with the many benefits of this type of conference between physicians, industrial nurses, insurance representatives, management, labor, and various state agencies concerned with the health and welfare of the worker. A rough check of our clinics shows that in three meetings we had more than 600 interested individuals in attendance, many of them physicians.

Speaking at the Kenosha clinic on May 7, a representative of labor commented upon the many times he observed a worker on the assembly line hail his family physician with the salutation "Hi, Doc." Members of his union are gratified to see that physicians are sufficiently interested in the health of workers to attend a plant tour and program.

In the ten years that the State Medical Society has been actively interested in the in-plant type of clinic there have been numerous instances when management has expressed its pleasure in having doctors of the area at their plants. Some of the companies have even furnished free dinners or luncheons to help stimulate attendance.

There is tangible evidence of the benefits of industrial health clinics to labor, management, and physicians. So long as we hold to the principle that knowledge of the patient's working conditions may be a valuable adjunct to treatment, alert members of the State Medical Society should continue to support the industrial health programs through active participation in the various clinics.

Non-Licensed Physicians in Wisconsin

In this issue of the *Wisconsin Medical Journal* appears the correspondence between Dr. A. G. Koehler, secretary of the State Board of Medical Examiners, and Mr. C. H. Crownhart, our State Society secretary, regarding non-licensed physicians in Wisconsin. As stated in Dr. Koehler's letter, it is well for the entire medical profession in this state to realize that anyone who practices medicine without a license is doing so in direct violation of the laws of Wisconsin and is subject to malpractice prosecution. It should also be remembered that any unfavorable publicity received by any physician reflects on the entire medical profession and, therefore, hospital administrators, those in charge of residents, and those taking on assistants, should be fully cognizant of the legal status of these employees.

Let's Have More Preliminary Reports!

The article by Doctors Paquette and Schmitz appearing in this issue of the *Wisconsin Medical Journal* is a preliminary report of a series of cases they are studying. Their investigation deals not only with the treatment of those patients already sensitized to the Rh factor, but also with the prophylactic use of progesterone and vitamin K in the non isoimmunized Rh negative patients with the thought of future pregnancies in mind. The work they are doing seems promising and may very well lead to a satisfactory treatment for sensitization to the Rh factor. However, even if this work does not prove to be as good as it now looks in their final evaluation, we think the men around Wisconsin who are working on various projects should send more of their preliminary reports in to the *Wisconsin Medical Journal* even though they plan on publishing their final results in a national publication. This will give our own Journal a lot of new and interesting material and, we believe, will be of some benefit to the investigators as they can expect constructive criticism from their colleagues while they are pursuing their investigations.

Has Estrogen Therapy Caused Development of Cancer in Women?

To date there is no such proof. Because a very special strain of sensitive mice have after receiving huge doses of estrogen over a prolonged period of time developed neoplasia in a high percentage of cases does not mean that women will respond in a similar way. There is no good reason for depriving women of the relief these drugs afford especially when therapeutic doses of one-half to one and one-half milligrams of estrogen or estrogen-like substances are administered.

Bleeding may occur during the administration or upon withdrawal of the drug. The physician should always be mindful that cancer may coincidentally develop during estrogen medication. Consequently the usual methods of investigation for such etiology should be carried out when indicated. In the case of the bleeding menopausal woman on estrogen therapy who presents a surgical problem, the physician should, before advising surgery, permit a sufficient period of time to elapse so that if there is withdrawal bleeding such bleeding will cease spontaneously. Furthermore cytologic and biopsy studies should always be obtained when there is any question as to the presence of uterine cancer.—ROLAND S. CRON, M. D.

Comments from the Wisconsin Press

Doctors' Opinion Needed

"Legislation recommended by the bipartisan Hoover commission to streamline federal medical services in a single unified department is making little progress, largely because of the failure of doctors to agree upon its principles. This bill, S. 1140, now before the senate committee on government operations, would coordinate and unify in a 'department of health' some 35 different medical agencies which are operating at cross purposes. . . . It appears that doctors generally agree the present system is extravagant and inefficient. Nevertheless, because of their disagreement on specific details they have not made a concerted and wholehearted effort to get behind the legislation. In fact the only group which has unswervingly supported this legislation is the national doctors committee for improved federal medical services which has committees in 48 states and has supplied witnesses at hearings supporting the bill. The attitude of the American medical association is difficult to understand. . . . Dr. Walter B. Martin, its spokesman, testified in opposition to the bill. 'The American Medical association,' he said, 'is in favor of the establishment of a department of health and is in wholehearted accord with the desire to effect economy in the operation of federal medical services'. . . . Dr. Martin, however, then raised objections. . . . Instead of suggesting amendments that might be acceptable to all parties, the association has given its ultimatum of opposition and backed out. This is a situation in which the 200,000 doctors of the country, independent of their own organizations, should do their own thinking and make their opinions known."—Waukesha Freeman, March 24, 1952.

* * *

Plan for Emergency Service

"The Racine County Medical Society has come up with a plan for improved emergency service in response to a plea by Fire Chief Rudolph Anderson. The plan, which would set up rooms in Racine hospitals where emergency patients can be brought, and provides that the hospitals obtain doctors in emergency situations, sounds workable and deserves an adequate trial. If necessary, changes or refinements can be made later.

"The problem of emergency medical service has been a growing one. . . . The medical men point out that there is a shortage of general practitioners in Racine. To get at the real base of the problem, the community and the medical profession itself should encourage more young practitioners to come to Racine and continue in general practice here. The GP is the backbone of the medical profession in any community."—Racine Journal Times, March 27, 1952.

* * *

Police Job

"Some California doctors have shown that they will cheat even their own professionally controlled, voluntary health insurance plan if they can get away with it.

"It is to the credit of the California Physicians' Service that it has acted to uncover the cheaters, and to admonish them. It indicates that the great majority of the participating doctors there, as elsewhere, do not condone that sort of thing.

"The medical profession, however, is somewhat on the spot. It has insisted that voluntary surgical and medical care plans, such as CPS, must be kept under the control of the doctors. The profession has resisted sharing responsibility or control, in health insurance, with either laymen or government.

"The doctors have stoutly defended their right to police their own profession, and thereby shouldered the responsibility for acting vigorously against malefactors—which they haven't always done. There must be drastic and effective remedies applied by the doctors themselves in such situations as that uncovered in California, if the profession is to keep the public's confidence."—Milwaukee Journal, March 24, 1952.

* * *

Complete Health Plans

"Complete health plans of some kind are on their way. Americans are somehow going to see that everyone gets adequate medical and hospital attention.

"We like the idea back of the co-operative health plans like now in use at Wild Rose and Tigerton. Health insurance of all kinds are wonderful, too, but most of them don't go all the way.

"The government has taken over the health problems in many countries. Just like our government found it necessary to take over school, highway and postal services. But let's not have government fill the health vacuum.

"Here is our big need! An adequate health plan for all, independent of government control. The American Medical association has been dragging its feet instead of finding the answers. We need fewer scare headlines about socialized medicine and more constructive ideas to do away with the need."—Wisconsin Agriculturist and Farmer, March 15, 1952.

The Third Party Payer For Hospital Care*

By HARRY BECKER
Associate Director, Commission on Finance of Hospital Care, Detroit

HARRY BECKER

OF THE many things that make America great—which set us apart from most other countries of the world—one is our never ending struggle to achieve a democratic society. Our greatness is not in the solutions we have found, but rather in our common desire to achieve the unrealized possibilities of our democracy. From this source, this philosophy, flows our vision, our determination to meet challenge. Within the stream of his philosophy we develop our concept of an expanding and dynamic society.

For the hospital administrator and the members of his board of trustees this expanding and dynamic society has created and will continue to create many new, often difficult problems. During the past decade the impact of our changing social and economic life has been felt more by the hospital than most other institutions. There are many reasons why this is true. The pressures for more services and for higher standards of care have been intensified at the same time that costs have more than doubled.

There is no mystery about the concern over the increasing cost of hospital care often expressed by the patient, the attending physician, the hospital, the prepayment plan, and the public welfare agency. It is not possible to expand standards of care, provide services to more people and still meet higher costs of operation without, at the same time, asking the consumer of hospital services for more money. The financial problem that confronts hospital administrators is, in large part, the direct result of a lag between the upward movement in costs of providing services and the willingness and ability of the buyer of services to pay the bill.

Hospital care, unlike most other elements of our standard of living, is something we cannot go without even if our understanding and acceptance of the cost of care lags behind the upward cost of providing necessary hospital services.

This is well illustrated by the fact that hospitals continue to provide care for recipients of public assistance even though state legislatures are unwilling to increase the allocation of tax money in direct relation to the rising cost of providing care. It is also shown in the public's reluctance to pay increased rates for prepaid hospitalization protection even though cost of living figures alone show the reason for higher premiums.

We should not be too surprised nor disturbed because the increase in cost of providing hospital care has created problems for us. What should concern us and give us cause for thoughtful and determined action is how we are going to meet the problems which have arisen. And, as we plan to meet our present day problems of financing of hospital care, we must at the same time give attention to those problems which will emerge in the near future.

Briefly, we can probably expect in the period immediately ahead a continued rise in hospital operating costs. Although in the past decade costs have risen at the rate of about 13 to 15 per cent a year—more than a percent a month—the rise in the next decade may be expected to be at a somewhat slower pace. It is also reasonable to assume in expanding consumer demand for hospital services and a broadened scope and supply of services. As a result the percentage increase in cost of prepaid hospital care, per thousand persons covered by a prepayment plan, may very possibly exceed the percentage increase in the daily cost of hospital operation. In other words, the relative rate of increase in monthly cost of prepaid hospital care to the public might exceed the rate of increase in daily cost of operating the hospital.

Another factor to consider as we develop plans to meet the problem of financing the cost of hospital care is the probability that the number of people per thousand population who will use hospital facilities will tend to increase in the future rather than decrease. This will occur at the same time hospital services are expanded to make more generally available such items as diagnostic and rehabilitation services. Also, the upward trend in our general educational level, the improved income status of the people, and the steady increase in the proportion of persons in the older age groups will be factors which tend toward more use of hospital services. We can probably expect, especially as the national defense expenditures reach a plateau, an increase in the total supply of hospital beds.

More funds, substantially more, will be needed for investment in facilities and equipment in the next ten years than were allocated for these purposes during the past decade. Likewise, the number of persons trained in the health professions will increase, and the amount of funds required for

*Presented at the Wisconsin Hospital Association Annual Conference, Milwaukee, February 14, 1952.

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training programs will gradually, but surely, move upward.

To some extent the pressures for greater utilization of hospital facilities may be offset by an increase in preventive care and improved productivity in hospital operation. But the effect of these compensating factors will, in the over-all, be relatively unimportant as major factors in reducing costs to the third-party agency. In fact, it might be argued that they may, in the short-term, tend to increase costs.

In our general consideration of economic problems confronting the hospital administrator we must not overlook the shift in source of hospital income. The percent of hospital income from endowments and charity sources is tending downward. This trend will probably not be reversed. The proportion of hospital income obtained directly from the patient at the time of hospitalization is growing less each year. At the time that these sources of hospital income have been reduced, the significance of the "third-party" payer has increased and will continue to increase.

The primary source of hospital income in the future will be payments made by third-parties. Persons actively employed are generally coming to appreciate that hospital care is an item of family expense that can best be met only through regular monthly prepayment. Today, approximately 75 million persons, or about one-half the total population, have some form of prepaid hospital protection. In the past ten years the number of persons participating in Blue Cross has tripled. It is reasonable to assume that in the next decade we should be able to almost double the number of persons who have prepaid hospital care and, at the same time, bring the levels of protection to a point where the full hospital bill is paid for under prepayment and third-party arrangements.

One of the significant gaps in population coverage by prepayment plans today is that, in general, the non-wage earners are excluded. This includes the public assistance groups, the unemployed, and retired workers. Also, coverage is lacking in most parts of the country for prolonged and chronic illnesses. All of our prepayment plans have important gaps in service, but the mechanism exists for closing these gaps and we can expect that over a period of time they will be closed. However, the problem of adequate financing of hospital care for the non-wage groups and for prolonged illness will not be easily met because we have not, as yet, developed the necessary arrangements.

Before the hospital administrator can provide the kind of service the public is demanding, and before he can maintain his hospital program at the standard dictated by present day medical developments, he must receive payment on a basis which will cover the cost of services rendered by his hospital. Moreover, until 95 percent or more of all patients are prepaid or whose care is paid for by third-party agencies the hospital administrator may expect to have difficulty meeting his budget.

Unfortunately, the dilemma he faces today is that with only fifty percent of his patients prepaid he cannot expect this prepaid group to cover the deficits created by less than full payment for services rendered other patients. Nor can he expect the 50 percent of his patients who are prepaid to carry the cost of training and research programs, capital replacement and expansion, and the full cost of such items as stand-by services. However, if all patients were prepaid, or received care under third-party arrangements some of these indirect patient costs could be absorbed by the prepayment plan.

The greatest barrier to expansion of prepayment plans is the cost to the individual of prepaid hospital care. If the entire cost of indirect patient services were generally included in the cost of hospital care to the prepayment plan, the rate of development of volúntary hospital insurance would be seriously retarded. To expect the prepayment plan and the third-party agencies to carry the full economic burden of indirect patient costs would result in such a serious financial load for the public that the plans would fail to accomplish their fullest potential. The hospital administrator must not be unmindful of the fact that the long range answer to most of his and the community's basic economic questions requires as rapid an expansion of our voluntary prepayment plans and the extension of satisfactory third-party arrangements as can possibly be achieved. This is particularly true for the marginal income groups in the community.

To succeed, these plans must, in the next few years, improve their standards of benefits to cover full cost of hospital care and expand their coverage to such groups as the unemployed and the aged. The increased monthly premium cost of such broader levels of protection as well as broader scope of coverage can be minimized in many ways. In cooperation with the third-party agency, the hospital and the physician must take every measure, consistent with high standards of service, to reduce costs of care provided the prepaid patient. In financing acute in-patient care for prepaid patients, too much stress cannot be placed on the need to safeguard against unnecessary expenditures.

Increased operating efficiency within the hospital is a factor in the control of costs to the third-party. Probably of more importance, cost-wise, in meeting today's economic problems would be such measures as the screening of patients to avoid admitting those who could be treated on an out-patient or home care basis. The establishment of procedures to assure early diagnosis and treatment, and prompt discharge when hospitalization is no longer necessary, is equally important. To illustrate, a ten percent reduction in the length of stay, or a ten percent reduction in use of hospital services per 1000 prepaid patients, if possible and desirable to achieve, could mean almost a ten percent reduction in the

cost of care for the prepaid group for whom the third-party agencies guarantee payments.

A serious economic drag on the hospital and on the community prepayment plan is the almost general practice of government, as a third-party payer, to expect hospitals to pay for patients hospitalized at public expense on a basis that represents less than cost of care provided. Government agencies, in most parts of the country, have expected hospitals to care for their patients without adequate reimbursement. There are historical reasons why this attitude exists and the hospital is partly responsible. However valid it might have been in the past to accept public patients at less than cost, there are reasons today why this practice is unsound both for the hospital and the public welfare agency.

Public welfare administrators are finding increased resistance on the part of legislatures to appropriate, in a period of full employment and high taxes, sufficient funds to maintain public assistance budgets at subsistence levels. Even harder is the task of getting enough tax money to meet the rise in hospital costs. The lack of sufficient tax funds to pay for hospitalization of the public assistance groups is accented because public welfare agencies have not only had to more than double their payments to keep pace with the rise in costs, but they also have had to start from a point below cost because hospitals traditionally have given care to the needy groups at an economic loss to the hospital. We cannot expect the public welfare agency to interpret the economic changes in hospital operation to legislators without the help of hospital administrators, their board members, and members of the medical profession.

The hospital administrator and the prepayment plan executive must be concerned about the difficulties that public welfare officials face in obtaining the funds necessary to pay the cost of hospital care for their recipients. And hospital administrators must be concerned with the character and operation of the community prepayment plans. Too often, day to day responsibilities at the hospital seem more urgent than does the need to meet with the executive of the prepayment plan to learn what help he needs from hospitals to make his program more effective as a public service. The prepayment plans cannot meet the public's need for hospital care or the hospital's need for adequate financing unless close cooperation exists between the third-party and the hospital.

From the long view, the problem of hospital financing is one of third-party payments. In the interests of the community the third-party agency must be a socially responsible organization. Our present nonprofit prepayment plans give hospitals and the public the necessary framework for a broad community program for prepayment of hospital care and a mechanism for adequate financing of community hospital services.

Whether or not these plans will develop into community agencies serving a major segment of the population depends to a very large extent on a mutual understanding between the plan and the hospital of respective interests and problems. The evidence is clear, for example, that the commercial insurance carriers are not going to be able to perform the job which is required for a sound community program for financing and developing hospital services on a cash indemnity basis which pays less than the cost of care. Hospital administrators and their boards must understand the basic differences, from a public and a hospital point of view, between the commercial cash indemnity plans and the non-profit service programs, and act accordingly.

Problems of payment to hospitals by third-party agencies are many and complex. The hospital and the third-party agency must find ways to resolve these problems in the interest of the public as well as in the interest of good hospital care. There is no reason, for example, why the amount of payment from the third-party cannot be adjusted to meet month to month changes in cost and to provide funds for plant expansion and replacement. Methods of paying hospitals must be employed which will encourage—not discourage—development of improved programs such as rehabilitation and out-patient diagnostic and treatment services.

If the third-party agency is going to underwrite hospital costs, the hospital must find ways to give the public and the third-party assurance that its costs are being held within reasonable limits.

A shift to third-party payments as the major source of income for the hospitals in a community means a new interpretation to the public of hospital as well as third-party costs. Present practices in hospitals with respect to methods for determining charges vary widely. Room rates, for example, seldom cover the cost of providing room services. On the other hand, such other services as laboratory, drugs and X-ray are often charged for at a rate exceeding their cost. Patients who pay their hospital bill directly tend to compare hospital costs on the basis of room charges or charges per admission. Prepaid patients, on the other hand, measure the costs of hospital care in terms of their monthly premiums for hospitalization insurance and not on the basis of hospital charges.

The implications of measuring hospital costs to the community by the monthly prepayments are many. The factors which affect the amount of monthly premiums are quite different than those factors which determine per diem costs. Although the per diem costs are an important factor they are not the only important consideration in determination of the monthly cost of prepayment. Utilization of hospital services per thousand persons covered is as important a cost consideration as per diem costs. In the future this and similar considerations, which evaluate hospital services in terms of the effectiveness of the protection and care provided for the whole community, will be used more and more as the measure of success of a hospital's program.

Hospital administrators and their medical staffs, to understand the economics of hospital financing under third-party payments, must become familiar with the factors that influence cost of prepaid care to the public, if the prepayment plans are going to meet public and hospital needs.

We are on the threshold of a new era in hospital financing and development of hospital services. Hospitals as we know them today have been underfinanced since their inception. The gap between the best that we know how to provide and what is generally available to people everywhere is still larger than necessary. In the next decade, real progress will be made in closing this gap. More people are going to participate through monthly prepayments in financing their hospital care.

And, with this broader base of financial participation in hospital financing there will be greater community concern with the character and scope of hospital services and with these costs translated into monthly premiums rather than room charges.

Whether we realize the potential that exists today for raising hospital standards and making comprehensive hospital services generally available depends on active cooperation and understanding by the public, the physician and the hospital of the underlying economic and social problems related to prepayment and hospital care.

The individual hospital, patient or physician can make or break prepayment as a social instrument.

An affirmative demonstration of the will to meet these new challenges will bring us one step closer toward achievement of our common goal—the best in hospital care for every community and for all people.

SCHEDULE OF PROGRAMS OF THE "MARCH OF MEDICINE"

On April 1, 1952, the March of Medicine began its seventh consecutive year of radio broadcasting. The programs, which are tape recorded, feature Dr. R. C. Parkin discussing various health problems with a lay person who is called "Your Medical Reporter." At present 33 stations in Wisconsin, one in Michigan, and one in Minnesota are cooperating in presenting this program as a public service feature. The most recent schedule is as follows:

Station	*City*	*Time*	
WHBY	Appleton	Saturday	8:30 a.m.
WBEV	Beaver Dam	Saturday	9:30 a.m.
WHKW	Chilton	Saturday	10:30 a.m.
WHWC	Colfax	Saturday	10:30 a.m.
WHAD	Delafield	Saturday	10:30 a.m.
WEAU	Eau Claire	Saturday	1:30 p.m.
KFIZ	Fond du Lac	Saturday	8:15 a.m.
WBAY	Green Bay	Saturday	9:00 a.m.
WHLA	Holmen	Saturday	10:30 a.m.
WJMS	Ironwood, Michigan	Saturday	8:15 a.m.
WCLO	Janesville	Saturday	6:35 p.m.
WLIP	Kenosha	Saturday	11:15 a.m.
WKBH	La Crosse	Saturday	11:00 a.m.
WLDY	Ladysmith	Saturday	10:15 a.m.
WHA	Madison	Saturday	10:30 a.m.
WIBA	Madison	Saturday	9:00 a.m.
WOMT	Manitowoc	Saturday	10:15 a.m.
WMAM	Marinette	Saturday	2:30 p.m.
WDLB	Marshfield	Saturday	8:45 a.m.
WIGM	Medford	Saturday	11:30 a.m.
WEMP	Milwaukee	Sunday	1:00 p.m.
WEKZ	Monroe	Friday	2:00 p.m.
WNAM	Neenah	Wednesday	10:45 a.m.
WOSH	Oshkosh	Saturday	9:45 a.m.
WIBU	Poynette	Thursday	2:30 p.m.
KAAA	Red Wing, Minnesota	Monday	9:15 a.m.
WOBT	Rhinelander	Saturday	8:30 a.m.
WHRM	Rib Mountain	Saturday	10:30 a.m.
WJMC	Rice Lake	Saturday	10:30 a.m.
WRCO	Richland Center	Wednesday	10:00 a.m.
WHBL	Sheboygan	Sunday	1:00 p.m.
WLBL	Stevens Point	Saturday	10:30 a.m.
WDOR	Sturgeon Bay	Thursday	9:15 a.m.
WDSM	Superior	Sunday	10:00 a.m.
WSAU	Wausau	Monday	4:45 p.m.

The Third Party Payer For Hospital Care: An Insurance Industry Viewpoint*

By GEORGE H. HIPP

Manager, Graup Divisian Emplayers Mutual Liability Insurance Company, Wausau

GEORGE H. HIPP

IT IS very easy to speak negatively. It requires no particular mental effort just to criticize. But to offer a positive solution to a real problem—or better yet to do that thing correctly—that is entirely another matter.

The insurance industry as a whole is earnestly endeavoring to help bring to the American public the broadest and the most comprehensive type of prepaid health care possible. We have only one requirement—the mechanism through which the payments for this prepaid coverage are dispensed must be on a sound financial basis. The program must be stable. The money to pay for the care must be forthcoming whenever and wherever the need arises.

Any such program while being responsive to improved technics and while recognizing new discoveries and developments must be built for the long haul. It must be able to ride-out stormy weather which most assuredly is ahead.

A short time back, I understand, hospital administration was a relatively simple business, but today it has a thousand and one facets. For our purposes today we shall cite only four parties that we consider inextricably interwoven in the over-all picture. They are the patient, his physician or surgeon, the hospital, and the third party payer. The rights of each are patent. The interests of each must be given due weight and consideration.

The hospital patient and his physician or surgeon are so closely tied together in this picture of proper care that I fear even though you might be completely or eminently successful in solving the hospitalization part of the problem the light of your success will be dimmed greatly unless like progress is made in solving the medical and surgical portion of the problem too.

The insurance industry is doing everything it can to help solve both problems. Alone we cannot solve this problem of financing proper hospital care for the public—nor can the hospitals alone—nor can Blue Cross alone—nor can labor alone. The solution will require the ingenuity of all. It is going to take the full contribution of each within his prescribed sphere.

However, each can become a catalytic force in bringing about the solution of the problem. Our industry here in Wisconsin has found that it learned and gained much in the field of medical and surgical care by cooperating with the doctors. Many of the Wisconsin State Medical Society leaders have made this same statement regarding the insurance industry. Each of us has learned from the other. Each of us is stronger because of that exchange of knowledge in a cooperative effort.

As a third party payer, what then does the insurance industry wish of the Wisconsin Hospital Association and the individual hospital administrators? We are begging for your cooperation in bringing to those of your patients who choose to use commercial insurance a well rounded, smooth running service including facility of admission and proper credit for benefits purchased by the patient in advance. We do not like ill-informed admission clerks to seize upon our policyholders as they seek admission into your hospitals and tell them what "lousy" hospitalization coverage they have, when in many instances the coverage carried is broader over-all than that proposed. We feel that such practice takes undue advantage of a situation.

An admirable beginning already has been made toward solving the admissions problem. Hospital admission plans have been initiated in over 30 metropolitan areas and districts. One of these plans is on a state-wide basis. This arrangement establishes a business like method of determining just what coverage an applicant for admission has, and then gives him credit to the extent of that coverage. This is a just and deserved recognition of the insured's foresight in protecting the hospital as well as himself by buying good prepaid hospitalization protection.

Parenthetically, Wisconsin well can be proud of its firsts in social welfare. It was the first state to pass a Workmen's Compensation Act in 1911. The Wisconsin State Medical Society established the first physician sponsored surgical plan that embraced both insurance companies and Blue Shield on an equal competitive basis. And the Milwaukee hospitals were one of the first groups of hospitals to establish an admission plan for commercial coverage.

I must mention here that casualty insurance and my own good company became a third party payer with respect to hospitalization and medical and

*Presented at the Wisconsin Hospital Association Annual Conference, Milwaukee, February 14, 1952.

surgical care back in 1911 when that first Workmen's Compensation Law was passed and each has distributed many millions of dollars in support of this care since then.

Another thing that the group insurance industry wishes from hospitals is the same rate of charges for identical services for all the patients in a given hospital. We do not feel that any class of patients should receive preferential treatment with respect to charges. In the past I have had individual hospital administrators tell me quite frankly that the contract rates being collected from certain types of third party payers were discounted from the rates being charged other classes of patients. Cash patients, public pay patients, Blue Cross patients and commercial insurance patients should get identical charges for identical services from the same hospital.

The net result of any other arrangement means that such favored patients are being subsidized at the expense of the cash patient or the commercial insurance patient. This is neither right nor fair.

The question now might be asked "Can the insurance industry write 'full service' plans?" The answer most assuredly is "Yes".

But over a wide geographical territory it is difficult to forecast proper premium charges because:

(1) Hospitals differ in whether they directly provide and charge for such miscellaneous services as ambulances, anesthetics, roentgenologists, blood transfusions, and the use of orthopedic appliances.

(2) Bases for hospital charges differ. Some hospitals use per diem rates while others use specific room and board charges and specific charges for other services as performed. Actually there are dozens of variations of these two basic arrangements. There are also arrangements under which the charges for auxiliary services depend upon the class of accommodations used by the patient.

(3) Under a full service arrangement there is possible abuse in utilization of hospital services because there are procedures that do not have a clear-cut objective standard to determine that their use has real medical value in which instance they take on the nature of a medical luxury. Unless some control could be established there is the feeling that there would be greater utilization of hospital services in such cases. In pursuing this point I am fully aware that such procedures usually are prescribed by the attending physician.

(4) Lastly we are in a period of rising hospital costs which will be reflected in hospital charges. If we charge premiums with a 10 cent base, we must pay for services whose cost is computed on that base. If we are to pay on a dollar base, we must use that base in computing the premium.

The insurance industry does have numerous risks written on a full payment basis. These risks generally are located in a community where the hospital costs have been steady and where there is little or no difference in the charges of the various hospitals in that community. We are watching these pilot plans closely—especially to see what effect they will have on charges in their respective areas.

If the hospitals could give the insurance industry some objective structure of charges for or costs of full payment against which rates could be computed, full payment would be the general thing.

If all of the interested parties will become objective, the prepayment problem in all fields can properly be solved and thus save for each party his particular sphere or field of activity.

1952 ESSAY CONTEST ANNOUNCED BY AMERICAN SOCIETY OF PLASTIC AND RECONSTRUCTIVE SURGERY

The Foundation of the American Society of Plastic and Reconstructive Surgery offers awards in junior and senior classifications for original contributions in this field.

Junior Classification: Two six month scholarships in leading plastic surgery services in the United States, England, and Italy will be awarded.

Senior Classification: The Foundation's annual prize, a silver plaque, will be given for the best essay presented at the annual meeting of the Foundation.

The contest is restricted to residents and surgeons in the practice of plastic and reparative surgery for not longer than five years. The subject matter of the essay should be the result of some original clinical or laboratory research in plastic surgery of recent date. All essays should be submitted in quadruplet form in English with no indication of the writer's name or his institutional affiliation, but should be identified by a legend. This legend should appear on the outside of a sealed envelope which contains the name, address, and affiliations of the contestant.

All entries must be received by the award committee not later than September 1, 1952. Further inquiries should be addressed to: The Award Committee, % Jacques W. Maliniac, M. D., 11 East 68th Street, New York 21, New York.

The Challenge of General Practice*

By PHILLIPS T. BLAND, M. D.
Jacksonville, Florida

IT DOES one good to return frequently to his medical school. After one has been in practice, even for a short time, he realizes that a bond exists between student and school, and the friendships and associations acquired during medical school years assume a new importance. In a very real sense, the physician in practice regards himself as a student of medicine because the education which begins at school continues in some form or another throughout his active years in medicine.

In addition, I welcome this opportunity to discuss a subject which concerns medical students as future physicians, as well as the relationship of the medical profession to the general public, and I may add, is a subject about which in a short time one can form a very partisan and definite opinion. The subject of general practice and the role of the general practitioner is of utmost importance in present day medicine and I hope by the following discussion to recruit some of the younger men to this segment of the medical profession.

Of what importance is this problem and why be concerned about the general practitioner? Is he the inevitable victim of medical progress or does he have a vital and necessary role in modern medical practice? I think we can best appreciate the present day situation by examining some of the changes which have taken place in the practice of medicine in the past several decades. At the turn of the century the vast majority of physicians in this country were engaged in general practice. There were no uniform standards of medical education and many practitioners had but very little formal medical training, having in many instances received practical training at the hands of an older, established practitioner who could be considered their preceptor. A physician who specialized under this period in American medicine often began as a general practitioner and as the result of special ability or interest in a particular field gradually limited his practice to that type of work, and so became a specialist by experience rather than by any well defined plan of continued training at the beginning of his career. The stereotype physician during this period was the legendary horse and buggy doctor; a physician who endured considerable physical hardships and whose weapons against the ravages of disease did not include antibiotic drugs and other modern innovations, but rather a working knowledge of human nature, infinite patience and consideration, and possibly a few drugs of doubtful efficacy.

With the advent of more uniform standards of medical education and licensure, plus rapid medical progress and such technologic developments as the mass produced automobile, this situation began to change. Rapid medical progress resulted in new and important medical discoveries which had direct application to then current problems of health and disease. It was only natural that specialization and the idea of a limited practice should grow out of this mushrooming of medical knowledge, and the era of specialization had begun. Certainly the development of the various medical and surgical specialties accelerated this process of medical discovery and, conversely, new trends and specialties resulted from these discoveries. In addition, specialization brought with it many advantages to the individual physician. These included an opportunity for continued training, increased professional prestige, a chance to augment his income, and in general more satisfactory working conditions. For these reasons, specialization has had and continues to have a powerful appeal for the majority of medical graduates, with the result that in recent years a majority of such graduates have entered the various medical and surgical specialties, while a minority enter general practice. This has created a critical shortage of physicians in many areas, especially those small communities and rural areas which formerly had a ready supply of physicians, inadequately trained as they may have been. It is the need created by this specific situation, that of a shortage of general practitioners in these areas, which offers a challenge to you as future physicians; a challenge and obligation which in my opinion is unequaled in present day medicine.

The importance of the general practitioner is also obvious when one considers the ideal organization of the medical profession. A balance must exist between the general practitioner and the specialties. The foundation on which advanced and specialized medical activity exists should be a base of an adequate number of active, well informed, and interested general practitioners. We must realize that, as a rule, the general practitioner is the first one consulted by the patient in the course of his illness and upon the general practitioner rests the primary responsibility for early diagnosis and adequate treatment of disease. Because of this close relationship between the general practitioner and his patient, we can form the concept of the general practitioner as the medical coordinator for that particular patient. By this we mean he should use his own knowledge and skill where adequate, and knowing his limitations, be able to guide the patient to adequate consultation and specialized help when

* Presented before the University of Wisconsin Medical School convocation, Madison, October 15, 1951.

necessary. There is no room for antagonism between the general practitioner and specialist in this sphere; the services of both are required for the ultimate good of the patient, and a practical, working relationship between the two should be the goal. Keep in mind then, this central role of the general practitioner as a medical coordinator.

Then there exists the problem of closing, where possible, the discrepancy which exists between recent medical progress and the application of such knowledge to present day medical problems of health and disease. It is true that such a cultural lag has existed in all phases of human progress, but in the field of medical progress there is great public pressure, and justifiably so, to narrow this gap as much as possible. In large measure this responsibility rests on the shoulders of the medical profession, particularly in those areas where the discrepancy is greatest; that is, the small communities and rural areas served by the general practitioner. Here this problem can be met only on the level of the general practitioner, and it is essential that the physician in these areas be aware of his importance in this regard.

I think then that we can summarize the importance of the general practitioner by noting how his importance increases with the present day tendency toward specialization; he is necessary in the sound organization of the medical profession; his close contact with patients makes him primarily responsible for early diagnosis and adequate early treatment of disease; and it is important for him to keep abreast of recent medical developments and make them available in so far as is possible to the people of his area.

Sooner or later the student of medicine arrives at that point in his career when a choice must be made concerning his future in medicine. From his contacts in school and elsewhere, the advantages of entering a specialty are well known and will of course greatly influence his choice. He may consider the prospect of entering general practice but ask, "In what way is it to my advantage to become a general practitioner? What are some of the rewards and compensations, and is there any future in that type of practice?" Admittedly such questions are difficult to answer because much of the reward and compensation of general practice lies in the realm of the intangible and is derived from the intense personal satisfaction inherent in this type of work. I realize that this is subject to a great deal of individual variation, depending on the motivating influences in one's life, but in general I think it is valid.

The first advantage, if it can be called that, is that as a general practitioner he can learn to know his patients. In recent years medical education has begun to stress the importance of this, and the field known as psychosomatic medicine has grown out of the failure of conventional medical practice to appraise the patient's symptoms or illness in terms of the patient as an individual. As a general practitioner, especially in a smaller community, he will be in an excellent position to avoid this error. For example, when the patient presents himself, the practitioner has probably treated him on a previous occasion and is aware of his past medical history. He will know the patient's family and have some insight into what personality types and illnesses are characteristic of that group and what effect they may have on the patient. In addition, he will know the patient's social and economic background as well as many other factors which may be of importance in understanding the patient. Then too, the patient often knows the practitioner as a friend and the rapport and understanding necessary to proper treatment are readily established and the patient is convinced of the physician's interest in his problem. It is in this realm of an intimate physician–patient relationship that modern medical practice has been negligent, and no one is better situated to correct this deficiency than the general practitioner. Someone has adequately expressed this point of view by stating, "It is important to know what kind of a disease the patient has, but it is equally important to know what kind of patient has the disease." The general practitioner has this opportunity to learn to know his patients and that is a valuable aid in the conduct of his practice.

Another advantage which general practice offers is an opportunity to see a wide variety of medical problems. A stimulating and varied diet is the general practitioner's bill of fare. This ready access to a wealth of clinical material, plus the observation of early and incipient disease, forms an invaluable part of his continuing medical education. It may be true that on some occasions he will require specialized help in diagnosis or treatment, but nevertheless he has learned something from this experience and at some future date will benefit from having had his diagnostic sense sharpened. So, under proper conditions, general practice can offer unusual opportunities to learn and apply the teachings of medicine. I might add that for those who have decided to enter one of the medical or surgical specialties, what better period of basic training is there than a period of time spent in general practice? Certainly one's perspective as to the relative importance of a specialty in the total medical picture will be improved.

In addition to these advantages, it is relatively easy to become established in general practice. There are several reasons for this. We have seen how in recent years fewer and fewer medical graduates were becoming general practitioners, with a resulting acute shortage of practitioners in many areas. This is often in contrast to the situation which exists in many cities, where the supply of physicians is adequate and where consequently the newcomer finds it somewhat difficult to become established. In addition, many small communities have attempted to avail themselves of the services of a physician by a community effort and have offered financial aid, medical equipment, and proper office space to any

physician willing to settle in their area. One cannot help but be impressed by the earnest desire of such communities for adequate medical coverage and their willingness to work cooperatively toward that end. So there need be no concern about becoming established successfully. A great need exists for the general practitioner and in a very short while he will have more than enough practice to occupy his time.

A final advantage of general practice is that, almost from the beginning, one has the sense of belonging to the community and of being an integral part of it. Small communities need people with educational and cultural backgrounds for their contribution to community life. University training could be put to no better use, and in addition to his practice, the physician can expect to participate in a variety of community affairs and to be consulted on related medical problems. He will be asked to participate in the preschool examination of children, school immunization programs, physical examinations for the high school athletic program, as an instructor in first-aid classes, and as a physician reference in the mass chest surveys for tuberculosis. In addition, he may be a local health officer, a position which in many areas of Wisconsin is not held by a physician. This will include the responsibility for the reporting of communicable diseases and the enforcement of quarantine, as well as other related duties. All of these activities are in the realm of preventive medicine and as such deserve his interest and attention. This diversified and enriching experience in community affairs will potentiate his usefulness to the community and will have a beneficial effect on his practice. This experience as both physician and citizen is, in my opinion, one of the more real and pleasant rewards of the general practitioner and is an experience frequently denied the practitioner in a larger community.

So from general practice the doctor can expect an intimate and useful physician–patient relationship and learn to know his patients; he will see a great variety of medical problems; he can expect relative ease in establishing a practice; and he can experience the satisfying role of being both physician and citizen.

Now we have briefly considered some of the advantages and compensations inherent in general practice and, in all fairness to the problem, should then consider some of the undesirable aspects of this type of practice which may present themselves. Admittedly there are real and compelling barriers to general practice in many areas which must be met and overcome if general practice is to be made acceptable to the majority of medical graduates.

The first and most obvious disadvantage is the sense of isolation which exists, with respect to medicine and medical progress and to the varied social and cultural opportunities of a large city and university area. Students of medicine are carefully nurtured in a carefully controlled environment of medical thought and activity, which certainly is the ideal medium in which the medical embryo can develop, but which makes the prospect of initiating an independent medical existence bleak indeed. I think it is one of the justifiable criticisms of modern medical education that the medical graduate has become dependent on the teaching staff and hospital facilities of his school to an extreme degree with the result that he has a poor estimate of his potentialities and capabilities as a practitioner of medicine. In addition, the complex subject matter of a medical education is of necessity interpreted and relayed to the student by those who are familiar and well acquainted with a particular subject, but often I feel that the subject matter is presented without proper perspective and emphasis as to its relative importance in the over-all plan of medical education. This sort of thing has a profound influence on the student with the result that he feels secure only with the addition of more training and does not detach himself as it were at an opportune time. Therefore, part of this sense of isolation is due to a mental or psychologic block from the type of training the medical student receives, and is a hurdle which must be overcome if one is to make an adequate adjustment to the environment of general practice.

This isolation is, of course, intensified by the lack of close contact with other physicians and the relative absence of laboratory and hospital facilities to which students have been accustomed. All medical students are aware of the the importance of informal discussions and the pooling of medical experiences in acquiring a medical education, and these excellent group discussions, the clinical pathological conferences and other such events are often lacking once one has started in practice. In addition, they have learned the importance of the laboratory in the diagnosis of disease and its use in determining the effectiveness of treatment, and they may be unwilling to undertake the responsibilities of a physician without such familiar aids close at hand. Undoubtedly the same reasoning will apply to hospital facilities. Very often a hospital may be 15 or 20 miles distant and may be lacking in terms of proper equipment or adequately trained personnel, all of which may seem incompatible with good medical practice. These factors, then, represent a serious criticism of general practice in many areas and serve to intensify the initial isolation of the general practitioner.

Another disadvantage to which the general practitioner is subject can be called an excessive work load. Unlike many other physicians, the general practitioner often has a singular community responsibility and very often is the only physician available in that area with the result that he is unable to call a temporary halt to his activities when necessary. Being constantly on call with an excessive demand on his time and service results in a steady attrition on the general practitioner's rest periods, his relaxation, and his family life. This physical and mental fatigue which is often the general practitioner's fate has, of course, a detrimental effect on

the quality of his work and of his attempts to keep abreast of recent medical developments. It would seem, then, that many of the shortcomings of the general practitioner are sins of omission due to overwork rather than reflecting a true compromise with the principles of good medical practice.

So on the negative side, the general practitioner can expect to feel a sense of isolation which is intensified by the lack of close contact with other physicians, a relative absence of laboratory and hospital facilities, and an oftimes excessive work load.

Now from brief experience, I will be rash enough to suggest that solutions can be found individually by the physician in general practice, and that these disadvantages can be alleviated to the point where they need not deter the would be general practitioner.

In the first place, we have seen how this sense of isolation is probably more apparent than real. The reaction of dependency produced by school experience is in part responsible for this, but this dependency will diminish after starting in practice because medical educational opportunity exists everywhere and is not confined to one area. At some point in every physician's medical education the seed or beginning of some sort of independent thought and action should have been planted, because surely it will find the climate of general practice favorable.

The isolation with respect to other physicians can be met in several ways. A physician starting in practice can very often on his own initiative develop a close working association with the other practitioners in his area, or in some cases a partnership between like-minded individuals may be of great mutual benefit. The advantages of such a cooperative effort are obvious. The excessive work load can be shared; he can discuss cases of mutual interest and obtain the advantages of more than one opinion; he can take a much needed vacation with a clear conscience and have time for study and collateral reading; finally he can attend some of the excellent postgraduate courses designed for the general practitioner. In this way, the physician in general practice feels as though he is able to maintain a high standard of medical practice, to keep abreast of recent medical developments, and to avoid many of the undesirable consequences of overwork.

The disadvantage with respect to inadequate laboratory and diagnostic facilities can be alleviated to a great extent in his own office. With present day equipment it is not difficult to create a small, efficient laboratory and to acquire the simple diagnostic equipment adequate for the majority of problems which he will see. The important thing is to have a continuing desire to constantly improve office organization and equipment in order to better utilize time and to minimize dependence. Here again, it is altogether possible that modern medical education has to some degree overemphasized the importance of the laboratory. The physician should not underestimate the importance of first knowing his patient through an adequate history and physical examination and then let this be his starting point in deciding which procedures are necessary.

The absence of nearby hospital facilities may on first inspection seem to be an insurmountable barrier to a practice, but in reality there are very few areas where a distance of over 20 miles separates the physician from an adequate hospital. A drive of 15 or 20 miles over an adequate paved road, such as now generally exists, is not a hardship and is certainly accomplished in less time and with less effect on one's blood pressure and coronary circulation than for example, a jaunt through Madison or Milwaukee traffic. So this distance can be considered a minor inconvenience rather than a barrier, and it will not hamper the ability to use hospital facilities when necessary.

In addition, it is important to develop an adequate system of clinical records for the office and to begin a medical library. By adding up-to-date textbooks and subscribing to a well chosen group of medical periodicals one can, in a very short time, develop useful references. Regular attention to such details, plus an active participation in the hospital staff and county medical society meetings in his area, will provide the basis for continued medical education.

It would seem then that in view of such a program, many of these disadvantages can be met with varying degrees of success, and should not discourage the future physician from that choice if he is so inclined.

At this point I would like to digress for a moment and consider some of the concepts the general public has about physicians and medical care. I think it is important for the general practitioner to be aware of this public pulse or opinion, because public attitudes may in the future determine the conditions under which medicine is practiced, and a knowledge of such attitudes will aid the practitioner in his practice. For the most part the job of public relations of the medical profession rests on the shoulders of the general practitioner, because the public will often judge the medical profession by the conduct and demeanor of the family physician.

It is a disturbing fact that the esteem and honor with which the public has held the physician has deteriorated some of late. Undoubtedly there are many reasons for this, but probably the most important one is in the matter of medical service. To physicians the term adequate medical care means both the services of a physician and readily available modern diagnostic and hospital facilities; but to people in general, and especially in smaller communities and rural areas, adequate medical care means simply having a physician available when necessary. There has been public criticism of the limited daily schedule of many physicians, and of the failure of physicians in a community to collectively provide a 24 hour, round the clock, emergency medical service for that area. Physicians may attempt to justify this conduct by stating that there

are very few actual medical emergencies and that many calls, especially at night, are unnecessary. Now this may be technically true from the physician's viewpoint, but I think such an attitude does not reflect a proper awareness of one's role as a physician. We do not expect a patient to be a physician and to evalute the importance of any symptoms he may have, nor do we expect parents to diagnose a child's illness. The object of a physician is the relief of suffering as well as the conquest of disease, and this suffering can be mental as well as physical. Therefore, to answer a call which allays the anxiety of a patient or of parents, even though their child has a relatively minor illness, is a necessary and humanitarian act; to refuse this is in effect to negate the moral and ethical basis of medical practice in the eyes of the public.

Another concept which one frequently encounters and which is in part fostered by physicians refers to the patient with an intractable and probably fatal illness. We often hear it said about such patients that nothing can be done or that the doctor has given him up. To encourage this sort of thing is to deprive the patient of any hope or confidence he may have and to create an undesirable situation with respect to the patient and his family. It may be true, for example, that a patient with an intractable malignancy has had the benefit of the most modern and careful surgical and x-ray therapy; yet there is much that can be done for that patient by the general practitioner utilizing the art of medicine. He can maintain a sympathetic interest in the patient and pay careful attention to such seemingly minor considerations as adequate sedation and proper nursing care; he can bolster the morale of the family by assuring them that everything practicable is being done for the patient; and he can help prepare them psychologically for the discouraging events which lie ahead. It is services such as these which are greatly appreciated by the patient and his family, and it is a grave error for the physician not to realize this. Oliver Wendell Holmes has said in this regard, "If you can do no good, then do no harm, for it is a poor physician who does not inspire hope."

In conclusion then, I hope I have stirred up more awareness of the importance of the general practitioner in present day medicine. He is essential in the sound organization of the medical profession, and his close contact with patients makes him primarily responsible for early diagnosis and adequate treatment of disease. Out of an urgent need for this type of practitioner, the challenge of general practice presents itself in a most urgent manner, and deserves utmost consideration.

Retain the concept of the general practitioner as a medical coordinator—as a physician with an intimate and useful physician–patient relationship who, by virtue of his position and experience, can best treat the patient as an individual. Consider also his role as a member of the community as well as a physician. Much will be expected of him in community affairs, and he will of necessity give freely of his time and service to the community, which only reflects his concern over the social and economic welfare of his neighbors as well as his concern over their medical well being. The rewards and compensations of general practice are great, and will be in direct proportion to his effort. True his practice and income will be more than adequate, but more importantly he can expect a great personal satisfaction in his work, which will far outweigh any of the inconveniences or disadvantages he may encounter. Finally, under proper conditions, general practice can be the best teacher of medicine because it permits continuation of education on a practical, working basis. The stream of medical progress does not pass by the general practitioner.

To future physicians I want to leave this message:

Consider carefully the advantages of general practice. In an honest manner examine some of the doubts and objections you may have. I think you will agree that they can be of minimal importance. I hope that before you graduate you will become acquainted with general practice on a first hand basis. Use the period of your preceptorship to examine and observe these conditions for yourself. The challenge is there; the opportunity is there. Think it over.

Naval Air Training Center.

ANNUAL CONVENTION OF THE INTERNATIONAL ACADEMY OF PROCTOLOGY

The International Academy of Proctology will hold its fourth annual meeting in Chicago, June 6, 7, and 8, at the Edgewater Beach Hotel.

The first two days will be devoted to a Seminar presentation of papers relating to the colon and rectum. The entire day of June 8 will be devoted to a teaching film presentation of surgical technics for diseases of the colon, rectum, and anus.

All physicians are cordially invited, whether or not they are affiliated with the International Academy of Proctology. There will be no registration fee.

The Use of Progesterone and Vitamin K in the Treatment of Rh Sensitized Pregnant Women*

A Preliminary Report

By L. J. PAQUETTE, M. D. and J. T. SCHMITZ, M. D.
Milwaukee

THE method of sensitization of the Rh negative mother is unknown. Levine and Katzin[1] have shown that the Rh antigen is not present in a water soluble form and was found only in the red cells. Thus, in order to produce immunization, there must be some type of break in the placental circulation allowing the escape of fetal cells into the maternal circulation. The amount of blood necessary for immunization need be a very small amount. Levine[2] has demonstrated in rabbits that, after a daily injection for seven days of 2 cc. of a 1:5000 suspension of citrated human blood, there was a distinct increase in the titer varying from 1:25 to 1:600. The total volume of blood employed in the seven injections was 0.0014 cc. The corresponding values for an adult of 120 pounds is 0.0336 cc. Various workers have demonstrated that numerous injections are necessary to immunize human individuals using minute amounts of blood if they have not been previously sensitized. If they have been previously sensitized, even if antibodies are no longer demonstrable, it is easy to restimulate the production of antibodies by small intravenous injections of blood (0.01 to 0.05 cc. of cells in 1 cc. of saline.)[3]

Dodds[4] has calculated that the total area of villi of a full term placenta exposed to the maternal stream is 70 square feet. The total length of the villi, if placed end to end, can be assumed to be over 11 miles. Thus the possibility for a break in the circulation is indeed great even in a normal pregnancy. This possibility is increased in Rh negative women because it is stated that Rh negative women have a greater tendency during pregnancy to uterine irritability and bleeding.

Most of the clinical work being done today dealing with the Rh problem concerns the treatment rather than the prevention or modification of erythroblastosis. Hoffman and Miller[5] recently reported preliminary work concerning an attempt to prevent the development of antibodies in the mother. Their aim was to encourage normal placentation and diminish uterine motility in an attempt to prevent even minimal amounts of fetal cells from reaching the maternal circulation. To accomplish this, they gave their patients progesterone and vitamin K throughout a large part of their pregnancies. Their results deserve confirmation and further investigation. Following are case histories of three multiparas who showed iso-immunization to the Rh factor at the time they became pregnant or very early in pregnancy.

CASE 1.—R. H., age 28, gravida 7. This patient delivered normal infants after her first and third pregnancies. The second terminated in miscarriage at 8 weeks; the fourth in a term infant which died one week post partum; the fifth in an 8½ month infant which lived less than one hour. It was jaundiced at birth. She received hapten throughout the sixth pregnancy which terminated in abortion at 5½ months. She received progesterone during the first half and vitamin K during the entire seventh pregnancy. Her seventh pregnancy started about 7 months after the termination of the sixth. The serologic record of her seventh pregnancy is shown in table 1.

TABLE 1—*Titer of Antibodies in Serum of Mother*

	3/13/51	5/18/51	8/6/51	8/21/51 (cord)
Acting in Saline	0	0	0	Rh Pos.
Acting in Albumin	1:2	1:2	1:4	
Indirect Coombs Test	1:2	1:8	1:16	
Slide Test	+2	+3	+4	

Labor was induced at 38 weeks. The patient delivered a mildly erythroblastotic infant who received an exchange transfusion. The child is now living and well. In spite of being iso-immunized from a previous pregnancy, this patient showed only minimal rise in her antibody titer until the last month of pregnancy.

*From the Marquette University School of Medicine and St. Mary's Hospital, Milwaukee.

TABLE 2—*Titer of Antibodies in Serum of Mother*

	10/21/50	10/25	11/16	1/27	3/8	4/7	5/5/51 (cord)
Acting in Saline	0	Progest. and Vit. K Started	0	0	0	0	Rh Pos.
Acting in Albumin	0		0	0	1:2	1:2	
Indirect Coombs Test	1:2		0	0	1:2	1:4	
Slide Test	+1		0	0	+1	+2	

TABLE 3—*Titer of Antibodies in Serum of Mother*

	1/13/50	6/16	6/23	6/30	7/5	7/12	7/21	8/9	9/8	9/12 (cord)
Acting in Saline	0	0	1:2	Progest. and Vit. K Started	0	0	0	0	0	Rh Pos.
Acting in Albumin	1:8	1:8	1:8		0	1:4	1:8	1:2	1:8	
Indirect Coombs Test	1:16	1:16	1:16		1:8	1:16	1:8	1:8	1:32	
Slide Test	+3	+3	+4		+3	+3	+1	+1	+3	

CASE 2.—M. D., age 41, gravida 5. This patient's first three pregnancies terminated in normal infants. The fourth terminated in a stillborn erythroblastotic infant of 8 months gestation. The serologic record of her fifth pregnancy, which followed her fourth by 2 years, is shown in table 2.

The baby was delivered at term. It was mildly erythroblastotic and received an exchange transfusion. It is now living and well. Of significance is the disappearance of antibodies as soon as treatment was begun. No demonstrable return was noted for 5 months.

CASE 3.—M. H., age 30, gravida 4. This patient received three pints of Rh positive blood early in her first pregnancy, which terminated in premature labor at 6 months. The second and third pregnancies resulted in jaundiced infants, although the third child is Rh negative. Both children received transfusions. The serologic record of her fourth pregnancy is shown in table 3. This pregnancy followed her third by nearly three years.

A total of 30 antibody titer determinations were made during this pregnancy. In addition to progesterone and vitamin K as shown in table 3, this patient received weekly injections of hapten throughout the pregnancy. Of significance is a moderate drop in the antibody level which began immediately after the addition of progesterone and vitamin K to the treatment. This drop was sustained until near the end of the pregnancy. The infant was delivered at term with moderate erythroblastosis. An exchange transfusion was performed on the child which is now living and well.

Summary and Conclusions

1. Case reports are presented of the pregnancies of three multiparas each of whom had delivered an erythroblastotic infant in the past and who showed antibodies at the start or very early in the reported pregnancies.

2. Progesterone and vitamin K appears to have a beneficial effect on Rh sensitized pregnant women.

All antibody determinations were made by the Rh Typing Laboratory, Junior League Blood Center of Milwaukee.

(Paquette) 425 East Wisconsin Avenue.

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ROCKY MOUNTAIN CANCER CONFERENCE SCHEDULED

The sixth annual Rocky Mountain Cancer Conference is scheduled to be held in Denver on July 9 and 10. Headquarters will be in the Hotel Shirley–Savoy.

The Colorado State Medical Society and the Colorado Division of the American Cancer Society, sponsors of the conference, have prepared a program which will feature eight guest speakers to discuss, primarily for the benefit of the general practitioner, the latest advances in the diagnosis and treatment of cancer. The speakers are specialists in the fields of surgery, pathology, pediatrics, radiology, dermatology, gynecology, and internal medicine. Each day there will be a round table luncheon discussion, and a non-scientific banquet with special entertainment is planned for the first evening.

A detailed program of the conference may be obtained by writing to the Rocky Mountain Cancer Conference, 835 Republic Building, Denver 2, Colorado.

Early Diagnosis and Effective Treatment of Depressive Reactions

By LEWIS DANZIGER, M. D., F. A. P. A.
Wauwatosa

OF THE common psychiatric reactions coming to the attention of physicians, perhaps the most satisfying to treat, as well as the easiest to diagnose, is the depressive state. Patients suffering from this type of disorder are very common in all age groups and ordinarily respond well to appropriate treatment given promptly and persistently. On the other hand those who are not detected, or who are treated inadequately, may suffer prolonged periods of disability during which they are exposed to unusual and unnecessary risks of death.

In most cases, the diagnosis presents little difficulty to the physician who is alert to detect the condition and who is able to spend the short time necessary for an adequate history and examination.

The most obvious complaint, of course, is of sadness, or depression, for which there may or may not exist some good reason in the patient's life situation. Sadness, however, is a symptom which many patients do not consider appropriate to refer to a physician. They may, therefore, complain first to other members of the family, to friends, or to a clergyman. Other patients may complain to no one until troubled by other symptoms which seem to them more truly medical or more properly the concern of the clergy.

Somatic Complaints

In any case, the saddened patient will usually have other complaints and symptoms by the time he calls for help. Some of these other complaints may be of a somatic type, as follows: anorexia, constipation, weight loss, disturbance of sleep, loss of libido, amenorrhea, chronic fatigue, or various abnormal sensations especially in the head and neck. The anorexia may be very slight and of such gradual onset that it is not noticed early by the patient or the family. It may be associated with or due to the other symptom of indecision, so that the patient is unable to decide what to eat and, therefore, eats nothing or too little. Or it may be associated with the general feeling that everything, including food, has lost its savor and that there is no pleasure to be had in any activity, even eating. Occasionally the patient may be hungry but feel that he is unworthy of food or that his eating will impoverish the rest of the family.

Constipation is often associated with anorexia. Some patients believe it unwise to eat because the bowels are not moving or because they believe, as a result of the constipation, that an intestinal obstruction exists. In some the constipation may be associated with inadequate intake of fluids, but in most cases the cause is not clear.

Weight loss is commonly due to the anorexia. Some depressed patients, however, eat normally and some gain weight. Some restless, tense, and anxious patients appear to eat more than normally and to eat more frequently than is their habit.

Disturbances of sleep may be of various types. The patient may have difficulty falling asleep, he may go to sleep promptly but then sleep fitfully, or he may wake up early in the morning. Commonly he finds the sleep less refreshing than usual. Some depressed patients, on the other hand, sleep more than normally and find some relief in this escape.

A decrease in the sex drive is common in both men and women who are depressed. Women, throughout the reproductive period, are likely to experience amenorrhea with depression; the return of the normal cycle sometimes precedes or accompanies other signs of improvement.

Many depressed patients, and particularly those who are tense and anxious, complain about the head and neck. Some have definite headaches, usually frontal or occipital, but more common is the feeling as if a band were around the head. Tension in the muscles of the neck, and particularly in the trapezius, may produce some pain in this region.

Other Complaints

Among the complaints more likely to be voiced first to the family or to the pastor are feelings of guilt or unworthiness. The guilt may refer to some sexual practice, desire, or fancy, possibly long since abandoned, or to some long past mistake or deception at work or at home. Some patients are unable to specify the guilt, but say only they have committed some sin for which they cannot be forgiven. Some Catholic patients may be relieved of the sense of guilt by receiving absolution from the priest, but with some Catholics this procedure is not effective. Similarly the feeling of unworthiness does not respond in all cases to clerical or other reassurance. The patient may feel unworthy of food, as mentioned above, or of employment, or of a recent promotion, or of some recent good fortune.

Associated with the feelings of guilt and of unworthiness, there may be delusions of a depressive nature. For example, the patient may believe his supposed guilt is known to the police, or that neighbors are discussing the matter, or that the shortcomings are being publicized in the newspapers or on the radio. He may misinterpret some advertisement, newspaper or radio item, or sermon as referring specifically to himself.

Depressed patients with somatic complaints may express bizarre ideas about their physical condition.

The head sensations may be interpreted as signs of a brain tumor. Delusions of loss are sometimes offered as explanations for the digestive symptoms, the patient saying he has no stomach or no bowels. Delusions of loss may also extend to the economic field, the patient then believing he has no money, no food, no job.

Indecision is also characteristic of depression. In some cases, particularly among elderly patients, this may give the impression of confusion or of memory impairment suggesting senile changes. In younger patients the indecision may be mistaken for preoccupation, vagueness, or blocking suggestive of schizophrenia or of mental deficiency.

The history of an earlier attack of similar illness supports the diagnosis of depressive reaction, but is not necessary. The first attack may occur at any age, and the first attack may be the last.

A symptom of special gravity is sudden, spontaneous improvement. Such improvement may mean the patient has at last broken through his indecision sufficiently to form a plan for suicide, or that he has been able to decide on a serious attempt at suicide in the immediate future. This decision is often accompanied by a feeling of relief so that the patient is able to seem cheerful and relaxed. Similarly, depressed patients who smile while expressing their complaints are usually considered more suicidal than others.

Suicide is an ever-present danger in depressed patients of all types. Religious beliefs, no matter how long or how sincerely entertained, provide only a very insecure defense and should never be relied on by the physician.

Prognosis

Contrary to a widely held belief, which is expressed in some textbooks, the prognosis in depressive reactions was not necessarily good before the introduction of modern treatment. In 1933, in the state hospitals of the United States[1] many depressed patients died in the hospital before recovering from the depression. Among the manic-depressive patients, most of whom were depressed, the deaths within the first five years of admission numbered 12 per 100 admissions. Among the involutional psychotic patients, most of whom also were depressed, deaths within the first five years of admission numbered 24 per 100 admissions. Very few of these deaths were from violence. Among the manic-depressives, only 37.3 per 100 admissions were discharged recovered in 1933. Among the involutional psychotic patients in 1933 only 20.9 per 100 admissions were discharged recovered. Some of the patients in each group who were discharged improved, probably recovered later at home. While these statistics of death and of recovery are not cheerful by modern standards, in 1933 they were considered good by comparison with the results obtained among some other types of psychotic patients.

Modern treatment has changed the situation radically. It is now recognized that some psychotic patients, including some of the depressed, suffer from deficiency diseases which respond dramatically to appropriate treatment. Some other psychotic patients recover when they cease to be exposed to a variety of toxic materials. Of the remainder, a large percentage will respond favorably to electric shock therapy. In this last situation, the result will depend largely on the number of treatment given; many of the failures may be explained on the basis of inadequate treatment.

Of a group of depressed patients recently studied here, 49 per cent had recovered by the time of the sixth treatment, but only 86 per cent had recovered by the time of the tenth treatment, and one patient in the group required a course of 16 treatments before he recovered. Statistical treatment of the results suggests that an occasional depressed patient may require more than 25 treatments. It is likely that in this group at least some of the failures were due to abandonment of the treatment too early.

Some of the patients treated safely and effectively suffered from advanced heart disease and some were over 70 years of age. In such cases, of course, extraordinary precautions were taken, and no treatment was given without previous consultation with an internist or cardiologist. The contraindications to electric shock therapy, however, are few and each year sees their number reduced.

In regions where electric shock therapy is not available, resort may be had to metrazol or insulin or both.

While shock therapies of all kinds are not without danger, the risks are small in comparison with the degrees of disability and with the probability of death presented by the disease. The risks will naturally depend in part on the skill of the physician and particularly on his training and judgment.

Summary

The principal symptoms of depressive reactions are as follows: sadness, anorexia, insomnia, amenorrhea, constipation, weight loss, loss of libido, chronic fatigue, abnormal sensations in the head and neck, feelings of guilt or unworthiness, delusions of reference or of loss, indecision and suicidal preoccupations.

Sudden spontaneous improvement may precede an attempt at suicide.

The prognosis without treatment is better than in some other psychiatric disorders but is not good. With modern treatment, including the relief of deficiency of diseases, the removal of toxic influences, and the application of shock therapy in adequate amounts, the prognosis is excellent.

The Milwaukee Sanitarium.

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Male Infertility

By J. W. SARGENT, M. D.
Milwaukee

THE problem of impaired fertility has, of course, been with us since the dawn of mankind. Only recently have the first steps been taken in the direction of a better understanding of the problem. I wish I could add that steps have been taken in the direction of specific therapy, but I can not. It is true that we know of a few specific types of infertility, some of which lend themselves more or less to corrective measures, but by far the vast majority of cases of infertility remain a problem without solution.

In spite of the many centuries that man has been concerned about his inability to reproduce, progress has been extremely slow. It has been only in very recent times that the male has even been considered as a factor in infertility. It now is estimated that about one-third of all barren marriages are infertile because of some defect in the male. When one considers that in the United States there are at least one and a half million couples desiring children and incapable of having them, one can conclude that there are about 500,000 husbands needing and desiring treatment for infertility.

Studies of the semen, of course, give us the most simple and direct means of evaluating the male in cases of infertility. However, the borderline between normal and abnormal is difficult to establish. It now seems apparent that the total sperm count is of little significance. Rather, the concentration *(i.e.,* the number of sperm per cubic centimeter of ejaculate) is important. While the average normal male produces from 120 to 135 million sperm per cubic centimeter, the lower limit of normal has been generally accepted as 60 million per cubic centimeter. There are, however, pregnancies recorded with counts as low as 2.25 million per cubic centimeter, and one well-authenticated case is recorded of pregnancy when the semen showed only 1 to 3 sperm per high powered field. Some recent studies on husbands of known fertility revealed that 25 per cent had sperm counts below 60 million per cubic centimeter and 12 per cent had counts of 30 million per cubic centimeter. On the basis of these and other studies MacLeod and others are currently accepting counts of 20 million per cubic centimeter as normal. I feel, however, that 60 million per cubic centimeter is a good borderline between normal and impaired fertility.

Morphologic studies of the sperm also give us added information although its value is questionable. In a normal ejaculate from 10 to 15 per cent of the sperm show obvious morphologic abnormalities. Twenty per cent abnormal forms is taken as the arbitrary borderline between normal and abnormal. Morphologic studies are not so significant because usually there is a constant relationship between the number of abnormal forms and the sperm count. If the sperm count is high, one never sees over 20 per cent abnormal forms, and as the sperm count decreases the percentage of abnormal forms increase proportionately.

Studies of motility are being recognized more and more as being very significant. Technically it is quite difficult to evaluate the actual per cent of sperm having good motility, and consequently the literature is somewhat confusing on this. From 60 to 70 per cent of the sperm should have a high degree of motility, but if as low as 40 per cent show good, active motility it may be considered normal.

There are many other characteristics of semen that have been studied and measured carefully, but as yet their significance is very questionable. For example, about one specimen out of ten is very highly viscous. But there is no correlation between viscosity and motility of the sperm, and viscosity itself does not correlate with infertility.

The accessory sex glands and ducts play important roles in infertility. One of the most important of these is the vas deferens. We are accustomed to think of the vas as a duct of importance only when there is disease at either one or the other end of it. Congenital absence of the vas is not too uncommon and must always be borne in mind. Inflammatory occlusions of the vas occur also, notably in tuberculosis and also in influenza and other systemic diseases.

The main function of the prostate gland is to add bulk to the ejaculate and also to supply the enzyme fibrinolysin. Fibrinolysin is produced in large amounts and is important in the liquefaction of semen. The effects of chronic inflammation of the prostate on infertility are equivocal. Most people now believe that chronic prostatitis is no factor in infertility.

The function of the epididymis is primarily of storage and maturation of the sperm. Sperm obtained from the head of the epididymis are infertile, while those obtained from the tail are fertile. Obstruction of the tubules of the epididymis, usually gonorrheal, is obviously a cause of infertility.

The seminal vesicles have two known functions. They supply most of the bulk to the semen and, interestingly enough, they convert glucose to fructose. Fructose is a sugar which is relatively rare in the human, and there are those who believe that this sugar is an essential source of energy for sperm cells.

The testes are, of course, acted upon by many diseases and conditions which we know impair or destroy spermatogenesis. In cryptorchidism if the cryptorchid testis is not placed in the scrotum

before puberty, it will remain incapable of spermatogenesis, regardless of whether or not it is later placed in the scrotum. Circulatory embarrassment to the testicle, as for example following herniorrhaphy, may result in atrophy with cessation of spermatogenic function. Poisons, particularly chronic lead poisoning and chronic arsenic poisoning, destroy germinal epithelium, and chronic alcoholism is a very real factor in inhibiting spermatogenesis. Morphine addiction also inhibits germinal epithelium. Mumps orchitis, when bilateral, results in sterility in 90 per cent of cases.

Chronic degenerative systemic diseases such as diabetes, nephritis, cardiovascular-renal disease, and malignancy result in degeneration of the seminiferous tubules which is roughly proportional to the duration of the illness. Tuberculosis is very important, and not necessarily genital tuberculosis. There is experimental evidence that the germinal epithelium is extremely susceptible to toxins liberated by the tubercle bacillus. Extragenital tuberculosis before puberty can and does produce complete destruction of germinal epithelium. Tuberculosis after puberty may produce large patchy areas of complete atrophy of the seminiferous epithelium.

Observations on the effect of acute infectious diseases bring out some interesting points. The germinal epithelium of the testis is very sensitive to acute febrile diseases. Whether the effect is due to toxins or to fever itself acting directly on the germinal epithelium is not known. During the influenza epidemic following World War I severe tubular epithelium damage was found in soldiers dying as shortly as 18 hours after the onset of symptoms. Undoubtedly any other acute systemic disease can and does produce profound changes in the testicle. Autopsy studies indicate that the testis is so sensitive that it is rarely possible to find normal testes in adults dying of acute infectious diseases.

The effect of febrile illnesses of short duration is even more interesting. Hotchkiss had been following a group of 167 men of normal fertility for some time when one developed a severe streptococcal tonsillitis. Within one month the patient's sperm count which had averaged about 119 million cubic centimeter dropped to 13.5 million per cubic centimeter with complete loss of motility. The count did not return to normal for two months, making a total of three months from the initial insult to the germinal epithelium to complete recovery. This time factor is significant and will be discussed in detail later. In another similar series a man was observed during a severe head cold. In three weeks his sperm count dropped from an average of 130 million per cubic centimeter to 28 million per cubic centimeter with very poor motility. It was seven more weeks before his count returned to normal. Still another case developed a true necrospermia, a complete loss of sperm motility, following a severe head cold, and it was three months before his semen returned to normal.

These observations are significant for two reasons. First, it becomes obvious that a semen analysis on any person who has had an acute infectious process within the preceding three months is, of course, totally valueless as it does not represent the true picture. Second, an analysis of the time intervals in these cases offers some interesting speculation. In each of these cases there was a lag of about a month between the initial insult to the germinal epithelium and the appearance in the ejaculate of abnormal sperm. Apparently the febrile illness impaired spermatogenesis in the tubules without at the same time affecting the adult sperm that had already been formed in the testis. Thus, this interval of one month represents the time that the newly formed adult sperm takes in migrating through the tubules of the epididymis and the vas to reach the ejaculate.

Again, in each of these cases there was an interval of approximately three months between the initial injury to the testes and the return of normal sperm. In other words, once the germinal epithelium is injured it takes at least two months for the epithelium to recover sufficiently under optimum conditions to produce normal sperm, and then another month for the sperm to migrate through the tubules to appear in the ejaculate. This makes a total of three months between the time that the noxious factor has been removed and the appearance of normal sperm in the ejaculate. Obviously, this is of great importance in evaluating therapy in these patients. The therapy must be continuous for at least three months and preferably more before anything can be decided about the effect of the treatment.

Now a word about the role of the testicular biopsy in infertility. We are still in the embryonic experimental stage as far as being able to recognize specific deficiencies (endocrine, dietary, etc.) from the microscopic picture of testicular tissue. The outlook is not entirely discouraging, and a great amount of work is now being done along this line.

From the practical standpoint, however, I would say that the testicular biopsy at present is of no clinical value in cases of oligospermia, that is, in which sperm are being produced but not in normal quantities.

In azoospermia, however, (that is, when there is a complete absence of sperm in the ejaculate) the testicular biopsy has some real value. If the biopsy shows normal testicular tissue, it becomes obvious that there is some obstruction in the tubular system connecting the testis to the prostatic urethra, and occasionally surgical procedures are successful in short-circuiting the point of obstruction.

If the biopsy shows a complete absence of any spermatogenic cells, then obviously no amount of treatment is going to recreate cells which will develop into sperm. This is important because the patient can then be told without reservation that no treatment will ever help him, and thus he can

be spared the emotional as well as financial drain of going from one physician to another and receiving countless numbers of expensive shots and pills in the vain hope that something will help him.

There is a third group of biopsies in which we can recognize histologically a specific endocrine deficit which may not necessarily be detectable clinically. Unfortunately this group is extremely small, but there is good reason to hope that this group will be expanded. This is the group in which the testicular tubules are still infantile, indicating a deficiency of pituitary gonadotropins, and replacement therapy in these few cases produces very satisfactory results.

The pituitary gland liberates two known hormones which act directly upon the testes, prolan A, or the follicle-stimulating hormone, and prolan B, or luteinizing hormone. Prolan A presumably acts directly upon the germinal epithelium to produce and maintain spermatogenesis, and prolan B acts upon the interstitial cell of Leydig stimulating them, in turn, to liberate testosterone.

In clinical pituitary deficiencies such as panhypopituitarism and hypogonadotrophic eunuchoidism the testes remain infantile, and replacement therapy with chorionic gonadotropins results in histologic and functional development of the testes to normal. Undoubtedly subclinical hypopituitarism plays a real role in infertility, but as yet we are not able to detect subclinical pituitary deficiencies sufficiently accurately to investigate these cases. For example, we can measure the urinary excretion of pituitary gonadotropins quite readily. But it is extremely difficult to tell how much of the gonadotropins are prolan A and how much are prolan B. Therefore, it is conceivable that a patient may have a normal urinary excretion of pituitary gonadotropins when further investigation would reveal that most of the hormones excreted were prolan B, and actually the patient was deficient in prolan A.

The thyroid gland plays a very important role in infertility. Subclinical hypothyroidism is definitely a major factor in a great number of patients having low sperm counts. It is not so much a factor in complete azoospermias, but it certainly is significant in many oligospermias. It is so important that I believe thyroid should be given to all oligospermias even in the face of a normal basal metabolic rate.

Estrogens may play a role in infertility. It is well known that small doses of estrogens produce a typical oligospermia, and as yet no one has excluded hyperestrinism in the male as a cause, perhaps a common one, of infertility.

Androgens are also important. It is well established that certain amounts of androgens within very narrow limits are essential to spermatogenesis. If there are less than this amount the testes atrophy, and in many cases androgens therapeutically will restore the testes to normal. Beyond this amount the androgens have a depressing or inhibiting action on spermatogenesis. Now again, there is no clinical test or typical biopsy picture by which we can identify subclinical deficient or excessive androgen secretion. The determination of urinary excretion of 17-ketosteroids is totally valueless in this respect, as our present tests for 17-ketosteroids do not differentiate between active androgens (androsterone) and the biologically inactive 17-ketosteroids such as etiocholanone, etc.

Recently Doctors MacDonald and Heckel of Chicago have reported some interesting observations upon the effect of androgens in oligospermia. They gave their oligospermic patients testosterone empirically. And they observed that in a certain per cent of these cases spermatogenesis was depressed completely to the point where no sperm appeared in the semen. Then, when testosterone was discontinued, after a period of time there was a rebound phenomenon and the sperm counts were raised to high normal for a while. This is still an experimental project, however, and is hardly to be used as a routine treatment of impaired fertility.

The role of the adrenals in infertility is completely unknown. The adrenals produce such a bewildering number of steroids that their identification and significance will take many years of work.

Among the general factors in infertility, the question often arises as to whether the frequency of intercourse is a factor. In other words, does too frequent intercourse dilute the semen enough to be a factor. My answer to this is no, it definitely does not. This idea of storing up the sperm for one grand occasion is without scientific foundation. In fact, I believe that the exact opposite is true. It is much more probable that too infrequent intercourse is a factor. At any rate it certainly is not logical or scientific to control rigidly the frequency of intercourse. I believe intercourse should be recommended entirely upon the emotional and physical needs of the couple. It should neither be limited nor forced but should be a perfectly natural fulfillment of desire without any strain or effort.

Complete mental as well as physical rest and relief from tension are very important as witness, for example, the cases we all have seen where a couple have been trying for years to have a child. They finally adopt one, and shortly thereafter the wife becomes pregnant—release from tension and strain and worry is very important.

Another question that often arises is whether an increase in the proportion of abnormal sperm predisposes to abortion or to genetically defective offspring. It is generally agreed that this has no effect on genetic inferiority or on the incidence of abortion. For one thing, the incidence of abnormal offspring is no higher among treated infertility cases than among the general population. In addition, defective sperm are due to a defect of function rather than a defect of the chromosomes.

There is one other factor in infertility which is rarely referred to in the literature but which everyone runs across sooner or later. This is the situation in which all known tests and examinations fail to reveal any deviation from the normal in either

the husband or the wife and yet no pregnancies ensue. We know that in Drosophila, the fruit fly, there is a lethal gene. When a male gamete having the lethal gene unites with a female gamete having a lethal gene, the entire process ceases. This has never been described in the human, but it might be a factor. In fact the theory can be carried a step further. In Drosophila again, there is a sex lethal gene so that all of the offspring are of one sex only. Whether this applies to the human or not is unknown, but it offers interesting speculation in cases having large families which are either all boys or all girls.

In conclusion, then, we must consider that male infertility is not a disease in itself but it is only a symptom, a symptom of many varied diseases and conditions. Until we can identify in each case the exact defect or mechanism producing infertility, we cannot hope for specific therapy. At present the means of detecting the deficiency in most of these cases is not at hand, and we must wait for further studies in the future. Until that day comes, however, all we can do is to exclude the known causes of infertility. We are then left with a large group of patients in whom nothing specific can be done. With these people I think the only thing that can be done is to first build them up to optimum physical and mental health. After that I think we are justified in giving them thyroid, if it is carefully controlled, and perhaps vitamin E. Beyond that I do not feel that we are justified in going any further at present. The indiscriminate use of expensive shots of gonadotropins, estrogens, androgens, etc., is entirely unjustified and must be reserved for a later date when we can first identify the specific deficiencies and then treat them rationally.

324 East Wisconsin Avenue.

BUREAU FOR HANDICAPPED CHILDREN SCHEDULES ORTHOPEDIC FIELD CLINICS

Orthopedic field clinics for the last half of 1952 have been scheduled by the Bureau for Handicapped Children, State Department of Public Instruction. The clinics are conducted for persons under 21 years of age who come within the state's definition of a crippled child. It is preferred that referrals be made by the family physician, but when this is not feasible, arrangements may be made by writing to the Bureau. Unless otherwise directed, forms for the purpose of referral may be obtained from the Bureau for Handicapped Children, and should be requested in advance of the clinic date. It is important that the Bureau know well in advance the number of persons to be examined so that plans may be made for the required personnel.

Families who return the signed referral form will be notified of the hour of their appointment a few days before the clinic. Parents and physicians are invited to attend the clinic with the child; and, if the public health nurse believes that the child referred to the clinic for orthopedic reasons is also in need of other services, the Bureau asks that it be notified of this fact.

Lancaster	July 9
Darlington	July 10
Eau Claire	July 24 and 25
Ashland	August 6 and 7
Wausau	August 20 and 21
Manitowoc	September 4 and 5
Marinette	September 10
Kenosha	September 16 and 17
Superior	September 19
Green Bay	September 25 and 26
Racine	October 9 and 10
La Crosse	October 15, 16 and 17
Sheboygan	October 23 and 24
Chippewa Falls	October 30 and 31
Eau Claire	November 13 and 14
Appleton	November 20 and 21
Fond du Lac	December 4 and 5

Inquiries concerning these clinics may be addressed to the Bureau for Handicapped Children, Room 146 North, State Capitol, Madison 2, Wisconsin.

Respiratory Symptoms Due to Esophageal Foreign Bodies in Infants

By ARTHUR C. TOMPSETT, JR., M. D.*
Sheboygan

DIFFICULT breathing with coughing, wheezing, and other respiratory symptoms is common in infants, and there is a wide range of possibilities as to the cause of such symptoms. When, however, the ordinary causes such as the common cold, tracheobronchitis, spasmodic croup, pneumonia, and infectious diseases in general are not present and there is respiratory difficulty, the more unusual conditions must be considered. Foremost among these one should suspect a foreign body either in the respiratory system or in the esophagus. The symptoms, signs, and roentgen findings in tracheal and bronchial foreign bodies are well known and have been thoroughly described in the literature.[1] However, no mention is found of the fact that esophageal foreign bodies may also cause a decrease in the tracheal lumen in infants with resultant respiratory difficulty as the most prominent symptom.

Other rare causes of laryngeal stridor and respiratory symptoms should be mentioned and may, of course, be the etiology in any given case. Among these are included thymic enlargement,[1-4] vegetative laryngeal papilloma, tracheal tumors, vascular anomalies, [1,5,6] congenital absence of tracheal cartilages,[7] and branchial cysts.[1]

Radiopaque foreign bodies in the esophagus are easily discovered by roentgen examination and may cause a marked decrease in the diameter of the tracheal air shadow in the lateral projection (Fig. 1 and 2). However, if a radiolucent object such as a bolus of food, a wooden block, or a plastic ball were present, the only sign on the roentgenogram might be a diminution of the tracheal lumen in the lateral projection. For this reason both posteroanterior and lateral projections should be employed. If the tracheal diameter is decreased and findings other than respiratory difficulty are absent, it would seem advisable to do esophageal studies with contrast media such as iodized oil.

The true cause of the decrease in size of the tracheal lumen in the presence of a foreign body in the esophagus is not definitely known.

Fig. 1.—White male 4 months old, admitted with an upper respiratory infection. Lateral roentgenogram of the chest demonstrates a normal tracheal diameter of 5 mm. at the level of the first thoracic vertebra.

Fig. 2.—The same infant at 6 months admitted with harsh productive cough, noisy "rattling" respirations, and a temperature of 104 F., rectally. Coarse rales were present bilaterally. The infant took its formula fairly well and did not vomit. The lateral chest roentgenogram shows a foreign body in the esophagus and a marked diminution in diameter of the tracheal air shadow to 1 mm. at the level of the coin. The lungs appear normal. After the coin, a dime, was removed by esophagoscopy the child recovered uneventfully.

*Radiologist, St. Nicholas Hospital.

The author wishes to thank Dr. L. M. Simonson for the clinical history of the case presented.

It has been shown that the size of the infant trachea is quite variable. In one study[8] it varied from a maximum of 7 mm. to a minimum of 2 mm. at the level of the fifth cervical vertebra, from 6 mm. to 1 mm. at the plane of the first thoracic segment, and from 5 mm. to 1 mm. at the third thoracic segment. A small percentage of apparently normal babies may have a tracheal air shadow measuring as low as 1 mm. and still exhibit no symptoms.

Nearly all foreign bodies, if they become arrested in the esophagus, are seen at the inlet of the chest at the level of the first thoracic segment. Since the trachea is so pliable at this plane even slight changes in pressure from an esophageal foreign body might result in a change in the tracheal diameter. Esophagoscopy in infants is often difficult because the introduction of the esophagoscope creates enough pressure on the trachea to cause respiratory difficulty. A foreign body might well act in a like manner.

In the case shown in figures 1 and 2 where a thin coin is the foreign body, the change in the trachea undoubtedly is due to a periesophagitis which is involving the thin membranous posterior portion of the trachea and decreasing its lumen. Such a condition may explain the fact that not all esophageal foreign bodies cause tracheal symptoms even in infants. It may be that patients who develop changes in the trachea have had a foreign body in the esophagus a sufficient length of time for a periesophagitis to develop, while other cases may be discovered before this inflammation has occurred and hence no change is seen in the trachea. The time element is often impossible to determine in babies.

In the literature no case was found where an esophageal foreign body had altered the diameter of an adult trachea. This may be because an adult would bring attention to such a foreign body before a periesophagitis had time to develop or because an adult's tracheal rings are much stronger and much more resistant to external pressure than the delicate tracheal structures of an infant.

Summary

Esophageal foreign bodies may cause respiratory symptoms in infants due to diminution in tracheal diameter. This change may be due to a periesophagitis or perhaps to direct pressure on the trachea.

Esophageal foreign bodies do not always cause changes in the trachea even in infants, and a normal trachea on the lateral roentgenogram does not rule out a foreign body in the esophagus.

Lateral as well as postero-anterior roentgenograms should be taken routinely when examining the infant chest. The tracheal air shadow should always be observed.

In an infant with respiratory symptoms and absence of other findings, further studies are indicated. If the diameter of the tracheal air shadow is diminished in the lateral chest roentgenogram, an esophageal study with contrast media would seem indicated to rule out a radiolucent foreign body.

Addendum

After this article was accepted for publication, the following article was discovered: "Foreign Bodies in the Esophagus with Symptoms Exclusively from the Air Passages" by H. Fr. Fabritus. Acta Paediatrica, 37:335–340, 1949. The author reports on the cases of two children in whom large radiolucent foreign bodies in the esophagus remained undetected despite repeated examinations. Neither of the patients had noticeable difficulties in swallowing but presented respiratory symptoms. No radiographs are included but mention is made of the fact that tracheal compression was present. The author emphasizes that roentgen examination with contrast media is a necessity.

St. Nicholas Hospital.

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EXAMINATION DATE SET BY STATE BOARD OF MEDICAL EXAMINERS

Examinations for licenses to practice medicine in Wisconsin will be held by the Wisconsin State Board of Medical Examiners July 8–10. The Board will meet in the Public Service Building, 231 West Michigan, Milwaukee.

Further information may be obtained by writing to A. G. Koehler, M. D., Secretary, Wisconsin State Board of Medical Examiners, 46 Washington Boulevard, Oshkosh, Wisconsin.

Immunization Practices and Procedures

(Prepared by staff members of the State Board of Health as a special service to Wisconsin's physicians.)

THE large number of articles on immunization practices and procedures which appear in current medical literature attest to the continued interest of the physician in this field of preventive medicine. Current modifications in the procedures recommended for protection against tetanus, pertussis, and diphtheria may be confusing unless the basic factors responsible for such changes are recognized and appreciated.

Success in the purification of toxoid antigens, particularly those of diphtheria and tetanus, is one such responsible factor. For example, presently available diphtheria toxoid is usually 70 per cent pure, as compared with the material used only a few years ago which was only 20 to 25 per cent pure. Vaccines containing alum precipitated or absorbed toxoids now also contain far less alum than previously. This permits the use of smaller volumes in injections, with a resultant decrease in local and general reactions to the immunizing biological.

A second factor responsible for the recommended changes in immunization practices is the extensive studies which have resulted in a better understanding of the antibody response of tissues to the stimulating antigens. Such studies have yielded much information of practical application to such questions as: What is the speed of antibody formation to varying quantities and types of antigens used in primary active immunization? What quantities and types of immunizing agents produce the greatest antibody levels? What is the effectiveness of the response to a single dose and to successive doses of vaccine, and what are the most advisable time intervals to secure maximum body response to such successive doses? How long does the immunized individual maintain effective antibody levels, and how much of the immunizing antigen is required to restore such effective levels? What is the safety and effectiveness of multiple antigen preparations as compared with individual preparations?

In general, studies along these lines indicate:

(1) That the use of alum toxoids produce an antibody response somewhat slower than that of fluid vaccines, but that there is a much superior antigenic response to the alum products.

(2) General reactions to multiple antigen preparations have not been found to be more severe than those to single preparations;[1] the use of the intramuscular route will greatly lessen the development of antigenic cysts.[2]

(3) Antibody response to an original injection of 1.0 cc. of multiple antigen seems to be no better than to that of 0.5 cc.; moreover, reactions are more severe with the larger dose.

(4) Two injections of multiple antigen given about one month apart give a very good response, *while response to a single injection is very inadequate.*

(5) A three injection series of multiple antigen given one month apart yields superior results[2] and is the method of choice.

(6) In a high percentage of immunized children there is an appreciable loss of diphtheria and tetanus antitoxin levels in three years.

(7) The reduction in the total number of injections required with multiple antigens is of decided advantage.

A third major factor to be considered in recommendations for immunization practices concerns the degree and duration of humoral antibody protection which is transferred from the immune mother to her offspring. Most newborn infants are susceptible to pertussis, and the severity of the disease in this group makes early immunization extremely advisable. It has been shown that 30 to 50 per cent of our adult population is susceptible to diphtheria,[3] and so a high percentage of newborn infants will secure no temporary immunity from their susceptible mothers. This also makes early immunization advisable. Tetanus toxoid is very well tolerated by young infants, and antibody response in this group is excellent. The fact that many infants still possess some degree of maternal antibody protection against diphtheria, and that response to primary immunization is not as great as in wholly susceptible infants, is one which cannot be advanced logically as a valid reason opposing immunization in this age group. Such a practice would leave a high percentage of newborn infants susceptible to this disease and pertussis during that period of life when such infants are least able to withstand these infections.

In general, the following immunizations schedule should be recommended:

(1) The use of multiple antigen preparations (alum precipitated or absorbed toxoids) is to be preferred for diphtheria and tetanus, and should be combined with pertussis vaccine.

(2) A minimum of three 0.5 cc. intramuscular injections should constitute a complete series.

(3) Such a series should be started at two to three months of age, and a month's interval between injections is recommended.

(4) One 0.5 cc. "booster" should be given between two to three years of age, and another at 5 years of age.

(5) Adequate immunizing levels may be maintained by the use of "boosters" as small as 0.1 cc. at three to four year intervals thereafter.

I should like to refer interested physicians to the excellent articles: *Whooping Cough—Still a Prob-*

lem, by J. R. Schroder, M.D.; *Diphtheria as a Continuing Problem in Public Health*, by M. J. Fox, M.D.; and *Modern Immunizing Agents Against Childhood Diseases*, by Gordon Worley, Jr., M.D., which appeared in the State Board of Health publication, "Health," March–April, 1952, for a more detailed discussion of this subject than can be contained in this space.—MILTON FEIG, M. D., *Director, Section on Preventable Diseases.*

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1. McGuinness, A. C.: Review of current trends in active and passive immunization, J.A.M.A. 148: 261–265 (Jan. 26) 1952.
2. Volk, V. K.: Safety and effectiveness of multiple antigen preparations in a group of free-living children, Am. J. Pub. Health 39:1299–1313 (Oct.) 1949.
3. McGuinness, A. C., Jodar, E. O., Miller, J. F.: Round table discussion: immunization review, Pediatrics 8:558–562 (Oct.) 1951.

RECENT WISCONSIN LICENTIATES

At a meeting held in Madison September 8, 1951, the following physicians were granted licenses by reciprocity by the State Board of Medical Examiners, after they had successfully passed an examination:

Name	*School of Graduation*	*Year*	*Address*
Arnesen, P. M.	New York	1947	4534 N. Wilson Drive, Milwaukee
Bartels, J. F.	Illinois	1944	5804 Cleveland, Morton Grove, Ill.
Belter, L. F.	Oklahoma	1946	5000 W. Chambers, Milwaukee
Capparell, H. V.	Pittsburgh	1946	1220 Dewey Ave., Wauwatosa
Burnikel, R. H.	Indiana	1940	Milwaukee County Hospital, Milwaukee
Howard, F. H.	Boston	1944	North 35th and Ajer, Milwaukee
Ingle, N. G.	Iowa	1944	16 South Henry Street, Madison
Kellogg, C. S.	Western Reserve	1946	98 Cherry St., Swanton, Ohio
McLane, W. L.	Jefferson	1944	11 N. Maryland Ave., Wilmington, Del.
Peterson, C. R.	Minnesota	1948	218 Rose Ave., Fond du Lac
Runkle, S. C.	Jefferson	1932	Box C, Waupun

The following physicians were granted licenses by reciprocity by the State Board of Medical Examiners following examinations at Madison, January 8–10:

Ahrens, C. F.	Minnesota	1945	St. Lukes Hospital, Duluth, Minn.
Arnson, J. M.	Northwestern	1917	1902 Rist Ave., Eau Claire
Babb, F. S.	Western Ontario	1938	844 Lowry Bldg., St. Paul, Minn.
Bostian, L. E.	Marquette	1949	10302 W. Auer Ave., Milwaukee
Caron, R. E.	Montreal	1945	Box 297, Piney Fork, Ohio
Coles, E. L.	Johns Hopkins	1949	1335 Astor, Chicago, Ill.
Curl, G. G.	Chicago	1947	311 Forest, River Forest, Ill.
Gustafson, Everette	Michigan	1944	104 Eddy St., Wakefield, Mich.
Hamlin, W. D.	Nebraska	1949	Mineral Point
Hilliard, G. W.	Meharry	1942	340 21st Ave. N., Nashville, Tenn.
Hindall, B. C.	Washington	1948	816 Wisconsin, Lake Geneva
Hopkins, C. E.	Syracuse	1945	408 Virginia Terrace, Madison
Leitschuh, T. H.	Minnesota	1943	11919 W. Bluemound, Wauwatosa
Lyons, W. H.	Stritch	1939	1012 Kales Bldg., Detroit, Mich.
Meister, M. M.	Wisconsin	1948	Milwaukee County Hospital, Milwaukee
Navarre, V. J.	New York	1949	2800 N. 4th St., Milwaukee
Palese, J. A.	Wisconsin	1948	1821 W. Wisconsin, Milwaukee
Rutter, Thomas	Harvard	1945	Jackson Clinic, Madison
Sickels, E. W.	Minnesota	1940	625 Lowry Bldg., St. Paul, Minn.
Spiro, H. M.	Buffalo	1939	Veterans Hospital, Tomah
Spitznagle, V. E.	Maryland	1935	5127 N. 31st Street, Milwaukee
Sweeney, J. E.	Johns Hopkins	1946	St. Joseph Hospital, Marshfield
Wood, R. A.	Minnesota	1945	5533 Woodale Ave., Minneapolis, Minn.

The following physicians were granted licenses by the State Board of Medical Examiners, following examinations at Madison, January 8–10:

Anderson, Evlyn M.	Iowa	1949	Milwaukee County Hospital, Milwaukee
Anderson, Isabelle J.	Wisconsin	1950	435 N. Randall, Madison
Annis, R. L.	Illinois	1950	1227–A Elm Lane, Milwaukee
Caldwell, Marian E.	Wisconsin	1950	1001 Grant Street, Madison
Guyon, Mary Ann W.	Marquette	1950	816½ Avon St., Flint, Mich.
Hassett, D. D.	Marquette	1950	2320 N. Lake, Milwaukee
Moen, C. B.	Wisconsin	1950	Evanston Hospital, Evanston, Ill.
Payne, Virginia L.	Wisconsin	1951	Wisconsin General Hospital, Madison
Taylor, B. C.	Baylor	1950	Wisconsin General Hospital, Madison
Troup, R. H.	Northwestern	1950	306 Cherry Street, Green Bay
Wochos, P. E.	Wisconsin	1950	5040 Wellington, Chicago, Ill.

THE MEDICAL FORUM

DOCTORS AND EDITORS SEEK TO IMPROVE REPORTING OF ACCIDENT CASES, NEW DRUGS AND TREATMENTS

Five Suggestions Come from Madison Meeting

Madison, May 8.—Five worthwhile suggestions for the improvement of medical-press relations came out of the second of the series of medical-press conferences.

About 100 physicians and representatives of hospitals, newspapers and radio stations met at Madison. Dr. H. E. Kasten, Beloit, acted as chairman; Mr. John Newhouse, staff reporter of the Wisconsin State Journal, spoke on the panel on behalf of the press and radio; and Dr. George Ewell, president of the Dane County Medical Society, spoke for the profession.

In summarizing the evening's discussion, Dr. Kasten and Dr. Ewell placed emphasis on the following proposals and problems:

1. Some physicians are willing to give reporters full information, but others are not. It appears that

(Continued on page 492)

Five More Conferences Planned

Five additional Medical-Press conferences will be held in various areas of the state during the month of May and June.

Conferences are now scheduled for:

APPLETON—May 22, Hotel Conway
WAUSAU—June 5, Hotel Wausau
LA CROSSE—June 19, Hotel Stoddard
SUPERIOR—June 26, Hotel Superior

These conferences will begin at 8 p. m. and continue until 10 o'clock. Each meeting will end with a buffet lunch, courtesy of the State Medical Society.

Plans include a conference for the Milwaukee region sometime during June if an appropriate date is available.

Dr. Heidner Opens Sheboygan Conference

Sheboygan, May 1.—The people most directly concerned with the reporting of news concerning patients' health and medical advances discussed their mutual problems in Sheboygan at the first of a series of regional medical-press conferences sponsored by the state and county medical societies.

Meeting together were physicians, sheriffs, police chiefs, and representatives of hospitals, newspapers and radio stations. The Sheboygan conference included representatives from Calumet, Manitowoc, Washington, Ozaukee and Sheboygan counties.

Dr. A. H. Heidner, West Bend, president of the state medical society, was chairman of the discussion. He said that a major sore point with physicians is that "so many new drugs and treatments are published before they are proved safe and before the doctor has information on how to use them."

Walter J. Pfister, associate editor of the Sheboygan Press, represented newspapers and radio stations. He said that most news of drugs and treatments originates from larger medical centers and reaches the newspaper via the wire services of Associated Press, United Press or International News Service.

He said newspaper men "assume that these stories have been checked for accuracy." If they are not, Mr. Pfister suggested, the American Medical Association ought to set up procedures for clearing such reports promptly and with accuracy.

Mr. Pfister said that getting news about the injuries and condition of accident victims was one of the hardest jobs of a reporter.

Physicians in charge of such cases are sometimes hard to reach

(Continued on page 487)

"Community Forums" on Health Pays Public Relations Dividends

St. Petersburg, Fla., May 1.—Enterprising county medical societies will be interested in the highly successful "community participation" forums staged by the Pinellas County Medical Society and a St. Petersburg newspaper. The forums have been attended by overflow crowds.

Common Health Topics

Once a week, in a church auditorium seating about 400, a local physician gives a lecture on a chosen medical subject. This is followed by a panel discussion in which four to six doctors participate.

So popular are the programs that after the first night's overflow crowd, two forums were presented each evening to combined audiences of 1,000 persons.

The forums explore such subjects as "The Common Cold," "High and Low Blood Pressure", "Hay Fever and Allergies," and "Arthritis."

Papers Pick Subjects

Subjects are chosen by the readers of the St. Petersburg Times, co-sponsor of the programs, through the medium of blanks printed in the paper.

More than 80 physicians and surgeons agreed to participate in the forums. Outstanding feature is the doctor's frankness and ability to talk about complicated medical subjects in layman's language.

LIBRARY OF THE COLLEGE OF PHYSICIANS PHILADELPHIA

Woman's Auxiliary Helps New Residents Get Acquainted with Health Services

Madison, May 1.—Troubled by the layman's frequent inquiry, "How can I get a doctor in an emergency?", the Woman's Auxiliary to the State Medical Society of Wisconsin has urged county auxiliaries to print and distribute "health service cards."

These cards may be printed in a variety of sizes, colors and shapes, but the message is usually the same—telephone numbers for the physician's answering service or exchange, hospitals, visiting nurses, family physician, police and fire departments, health department, and pharmacy.

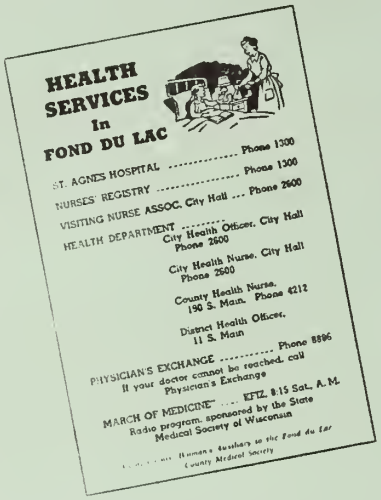
In addition, they usually carry a "plug" for the March of Medicine, the weekly radio health broadcast sponsored by the State Medical Society.

The Fond du Lac County auxiliary was the first to print and distribute such a card in Wisconsin. Three hundred copies were supplied to the Welcome Wagon in Fond du Lac, an organization which calls on new residents in the city to acquaint them with the city's business and service facilities.

Rock county auxiliary members prepared a card for the Beloit Welcome Wagon hostess. About 400 copies were printed for use during 1952. Members in the Janesville area are preparing a similar card for that city.

In Green Bay, auxiliary members printed 500 stickers carrying information on health services, and several other auxiliary units have plans to prepare similar cards or stickers during the summer.

The auxiliaries report the cards are gratefully received by newcomers in every city, thus contributing to improved public relations with the medical profession.


HEALTH SERVICES
In
FOND DU LAC

ST. AGNES HOSPITAL ..... Phone 1300
NURSES' REGISTRY ..... Phone 1300
VISITING NURSE ASSOC. City Hall ... Phone 2600
HEALTH DEPARTMENT ..... City Health Officer, City Hall Phone 2600
City Health Nurse, City Hall Phone 2600
County Health Nurse, 190 S. Main. Phone 4212
District Health Officer, 11 S. Main
PHYSICIAN'S EXCHANGE ..... Phone 8896
If your doctor cannot be reached, call Physician's Exchange
MARCH OF MEDICINE ..... KFIZ, 8:15 Sat., A.M.
Radio program, sponsored by the State Medical Society of Wisconsin
Women's Auxiliary to the Fond du Lac County Medical Society

Papers Cooperate in Publicizing M.D. Service

New York, May 1.—The Tioga County Medical society in New York state has a unique and effective method for publicizing its emergency service.

Six weekly newspapers covering the county cooperate with the society by publishing in a box on the front page, the names of the doctors who are on call each weekend throughout the year.

Earmark $59 Million for Medical Supplies in Civil Defense

Washington, D. C., April 29.—Approximately 70 per cent of all federal money spent on civil defense is going for medical purposes, principally matching grants to states for local medical stock piling and all federal regional stock piles.

So far the Federal Civil Defense Administration has earmarked $50,000,000 for federal medical purchases and $20,000,000 to be used for matching grants to states

According to a report recently issued by FCDA administrator Millard Caldwell, about $90,000,000 in medical supplies will have been procured or will be on order by next June.

Wisconsin has already placed its orders for about $200,000 in medical supplies to be stored in Wisconsin and used in the event of local emergencies.

Within the next year a total of 58 regional federal warehouses will be available for stock piling federal supplies, including engineering as well as medical equipment. These supplies will be stored in such a way that they are immediately available at the time of emergency.

In case of a local emergency, the community will have to depend upon its own medical supplies and services for the first few hours, awaiting the arrival of medical units from the nearest federal regional warehouse.

Dr. Shields Named to Public Health Post

DR. WHITE HEADS STATE SANATORIUM

Madison, Apr. 1.—Dr. Gregory G. Shields, Abbotsford, has been appointed health officer for public health district 5. This includes the area of Buffalo, Clark, Jackson, Marathon, Pepin, Portage, Trempealeau and Wood counties.

Dr. Shields is a 1932 graduate of Marquette University medical school. He has practiced medicine in Abbotsford for nearly 20 years. His new headquarters will be in Wisconsin Rapids.

Laboratories Approved

The state board of health also announced the appointment of Dr. Ellison F. White as superintendent of Wisconsin State sanatorium. He has been serving as medical director of the sanatorium.

Four laboratories were named by the board as the first to be certified for scientific testing of water and milk under a laboratory certification law passed in 1951. They are the Milwaukee Waterworks, water testing; Chippewa County Co-op Dairy, Bloomer, milk testing; Eau Claire City-County Health Department, water and milk testing; and the State Dairy and Food control laboratory of the state department of agriculture, Madison.

National Nursing Groups Consolidate

New York, April 15.—Before next fall, nursing expects to have a new national organizational structure.

Instead of the six national organizations that are now concerned with professional nursing there will probably be only two. These will be the American Nurses Association and the National League for Nursing.

Under a reorganization plan now under consideration, the National League for Nursing would replace and carry forward the major programs of four organizations—the American Association of Industrial Nurses, the Association of Collegiate Schools of Nursing, the National League of Nursing Education, and the National Organization for Public Health Nursing.

Notice to Doctors Under 34— Low Rates for Disability Plan

Madison, May 1.—Members of the State Medical Society under the age of 34 have an opportunity to participate in the Society's Group Disability Plan at reduced rates if they enroll prior to August 15, 1952.

These physicians may now enroll in the group disability plan for $50 weekly income benefits, plus all other benefits of the regular plan in full, at a cost of only $61 annually ($30.50 semi-annually.)

While reducing only the weekly income benefits by one-third, the cost of their regular plan has been lowered almost 50 per cent. This new plan is available only to physicians under the age 34 and may be continued only until the first premium due date following the 34th birthday, or the premium due date after the coverage has been in force for twelve months, whichever date is later.

At that time the regular plan will go into effect automatically at regular premium rates without evidence of good health.

Among the outstanding features of the program are:

1. Benefits are payable for disability commencing after effective date of the policy regardless of when the condi tion had its inception.
2. No restrictive riders may be imposed on any certificate by the insurance company either now or later, so long as the group contract with the Society remains in force.
3. It is 33 to 50 per cent less expensive than individual policies.
4. There are no exclusions except suicide, war, and operating an airplane.

It provides around-the-clock protection for sports and recreation as well as professional duties Details of the modified plan have been sent to every physician affected by this program. These physicians are urged to complete and return enrollment cards promptly. Physicians wishing further information are urged to write the office of the State Medical Society.

EXPECT EARLY DECISION ON TAX DEDUCTION FOR DOCTORS' P-G STUDY

Chicago, April 28.—The American Medical Association has taken another step in its long fight to get the Internal Revenue Bureau to permit physicians to deduct expenses incurred in the pursuit of postgraduate study from federal income taxes.

The A.M.A. has been interested in this question for a long time. Thirty years ago the internal revenue commissioner ruled that a doctor's postgraduate expenses were personal in nature and, therefore, not deductible for income tax purposes. On numerous occasions the A.M.A. House of Delegates expressed the viewpoint that this ruling was in error and urged its reversal, but, to date, all efforts have been futile.

Recently, the A.M.A.'s legal department learned that a case was pending before the U. S. Tax Court in Washington involving the right of a lawyer to deduct expenses incurred by him in taking a special course on federal taxes.

Since the lawyer's problem and that of the physician are identical, the A.M.A. filed a brief as a "friend of the court."

The A.M.A. set out numerous arguments in support of its stand It said that "in order to maintain and preserve their professional practice, lawyers, doctors, architects, engineers and accountants necessarily engage in a continuous process of education throughout their professional lives. For professionals cannot adequately serve their clients or patients unless their precious fund of knowledge is always kept fresh and intact . . . . The expenses of maintaining professional competence easily qualify as deductible business outlays. Obviously, the sums paid are directly connected with a trade or business. They are intimately related not only to the various professions, but to the production of income from those professions."

The Tax Court is expected to hand down a decision shortly.

PRESS CONFERENCE AT SHEBOYGAN—

(Continued from page 485)

just before newspaper deadline time, and even when contacted may not wish to reveal information about the patient's condition, he stated.

He suggested that physicians authorize hospitals to give general information about the nature of injuries and condition of accident victims.

Dr. C. G. Reznichek, Madison, member of the council on medical service of the state medical society, indicated that such a plan might be workable if the procedure for accomplishing the plan had adequate safeguards for the physician on the matter of his confidential relationship with the patient.

CLAIM BLANKS

A Wisconsin doctor is likely to handle more TIME claim blanks than any other company's. TIME, a leader in the accident and health insurance field, insures a large portion of the total number of persons carrying such insurance in Wisconsin.

Few doctors appreciate the great service given to their patients when these claim forms are handled promptly.

Any suggestions from you as to how our claim forms may be improved will certainly be appreciated.

• • •

The Time Insurance Company

215 WEST WISCONSIN AVENUE

Milwaukee 3, Wis.

SPEAKERS' TABLE AT MILWAUKEE industrial health clinic reveals (left to right) Dr. H. Glenn Gardiner, Chicago, president of Central States Society of Industrial Medicine and Surgery; Dr. N. J. Wegmann, president of the Medical Society of Milwaukee County; James O. Kelley, executive secretary of the Milwaukee society; A. J. Finke, safety director, Miller Brewing Co., and Dr. E. M. Dorr, Chicago, assistant professor of obstetrics, Northwestern University School of Medicine.

Industrial Health Clinics Draw More Than 500 Persons in 1952

Madison, May 10.—Despite sleet and rain, more than 500 physicians, nurses and plant managers turned out for the 1952 Industrial Health Clinics, according to Mr. Roy T. Ragatz, assistant secretary of the society.

The clinics are sponsored by the committee on industrial health of the State Medical Society; industrial hygiene unit of the State Board of Health and the industrial nurses section of the State Nurses Association, in cooperation with county medical societies and the industrial plants which act as clinic hosts.

The Milwaukee clinic was held at Columbia Hospital and the Miller Brewing Company plant on March 13. The Central States Society of Industrial Physicians and Surgeons participated in the session, and part of the clinic was held in connection with the March meeting of the Medical Society of Milwaukee County. More than 300 attended in spite of one of the winter's worst snow storms. Highlight of the session was a discussion of problems of women in industry.

More than 100 physicians, plant managers and nurses met in Eau Claire for the second clinic on April 2. The U. S. Rubber Company plant opened its facilities for a plant tour. Scientific discussion related to treatment of back strains, dermatitis and saving the injured hand. The Eau Claire–Dunn–Pepin county medical society acted as host.

On May 7, the third clinic was held at the Nash–Kelvinator Corp., Kenosha, in cooperation with the Kenosha county medical society, the local manufacturers association, and the Wisconsin Heart association.

Nearly 150 attended discussions of rehabilitation of workers in industry, special problems of handling cardiac cases in industry, and efficient employability of older workers and the conservation of executive personnel.

Society Cooperates in Health Workshop

April 15.—The Oshkosh State College is offering a six weeks Health Education Workshop this summer from June 23 to August 1.

The conference is being presented in cooperation with the State Medical Society, the Wisconsin Cancer Society, the Wisconsin Anti-Tuberculosis Association, the Wisconsin Foundation for Infantile Paralysis, and the National Society for the Prevention of Blindness.

The workshop will be under the direction of Mrs. Catherine K. Campbell, school health consultant of the State Board of Health.

The State Medical Society will cooperate in this program by furnishing teacher education materials and arranging a lecture presentation by Dr. Edgar S. Gordon, associate professor of medicine, University of Wisconsin.

Other staff members will include Mr. Frank Stangel, health coordinator of the Milwaukee City Schools; Dr. E. B. Pfefferkorn and Mrs. Elizabeth Toland, R. N., of the Oshkosh College faculty; Miss Martha E. Study, State Board of Health nutritionist; and Mr. A. B. Abramovitz, supervisor of clinical psychology, of the State Board of Health.

Drs. Wier and Shinners in Civil Defense Posts

Madison, May 2.—Dr. John S. Wier, Fond du Lac, and Dr. George M. Shinners, Green Bay, have been selected as area co-directors of health services for two civil defense areas in the eastern part of the state.

Doctor Wier will serve in this capacity for the area involving Outagamie, Winnebago and Fond du Lac Counties.

Doctor Shinners will serve the area consisting of Marinette, Oconto, Shawano, Brown, Kewaunee, and Door Counties.

The responsibility of these area co-directors for health services includes direction of several mobile medical teams, meeting with other area co-directors to plan transportation facilities and police and fire protection, and coordination of the health services of city civil defense setups.

DOCTORS WIVES START "CRUSADE FOR NURSING"

AUXILIARIES RAISE $3,000 TO HELP STUDENT NURSES GET THEIR "CAPS"

Madison, May 1.—In a dramatic public relations project, the Woman's Auxiliary to the State Medical Society of Wisconsin is proving that something CAN be done about the nursing shortage.

In addition, they are proving something else—that Wisconsin doctors' wives are willing and able to lend personal assistance and financial help to promote better health and thus improve the public relations of the medical profession.

Nurse recruitment isn't the easiest thing in the world. But that didn't dampen Mrs. Victor Falk's spirits. She lives in Edgerton, but the state has been her front yard during the past year ever since she became chairman of nurse recruitment projects for the Woman's Auxiliary. And look at the results:

Twelve auxiliaries offer nearly $3,000 in scholarships and loans to prospective student nurses.

Nine auxiliaries sponsor special recruitment programs to encourage young women to enter the nursing profession.

Members of all county auxiliaries will help place nurse recruitment "notebooks" in more than 500 high schools this year.

Dane county wives have a $50 and $100 interest free loan fund for student nurses enrolling in any of four Madison hospitals. Douglas county offers $25 scholarships from a $300 fund.

Counties Offer Help

Fond du Lac county offers a $360 loan to a student enrolled at St. Agnes' hospital. A $200 fund is available to a student from Green Lake or Waushara county. The La Crosse auxiliary offers a $50 gift to a student entering nurses training anywhere in Wisconsin.

The Milwaukee county auxiliary has two $250 scholarships and three $100 loans available to qualified students enrolled in Milwaukee county's hospital training schools.

A $300 scholarship may be used at St. Luke's hospital training school in Racine, through the Racine county auxiliary. Rock county wives have a $250 scholarship for use at Mercy Hospital, Janesville.

Sauk county doctors' wives help local girls with a $50 scholarship. Sheboygan county auxiliary offers high school graduates of Sheboygan county an opportunity to obtain a scholarship in an amount determined after the student is accepted in an accredited school.

MRS. V. S. FALK, JR.

A Walworth county girl may obtain a $250 scholarship from the Walworth county auxiliary if she trains at Mercy hospital, Janesville. The Washington–Ozaukee auxiliary offers $150 for use of a nursing student at any accredited school in Wisconsin.

The Brown–Kewaunee–Door medical auxiliary gave recruitment talks at six high schools. Calumet county doctors' wives personally interviewed prospective nursing students. Crawford county plans to set up a loan fund.

Auxiliary members in Columbia–Marquette–Adams county entertained likely nurse candidates with a meeting, film and discussion.

Dodge county wives presented a program to 40 girls in Beaver Dam high school. Manitowoc members arranged poster displays, meetings and teas. The Outagamie county auxiliary has shown nursing films throughout the county junior and senior high schools.

Polk county physicians' wives have distributed posters and given talks. Winnebago county auxiliary members held "open house" for nearly 200 girls who might be interested in nursing as a career.

"The best is yet to come," according to Mrs. Falk. The state auxiliary is giving $250 and lots of time and effort to help the Wisconsin State Nurses Association and the Wisconsin State Department of Nursing provide "notebooks" for some 500 high schools.

These notebooks contain bulletins from every accredited nurses' training school in Wisconsin and will provide educational data for career guidance counselors and prospective students.

"Rock and Dane county auxiliary members will compile the material," said Mrs. Falk, "but every doctor's wife in the state will be expected to help deliver the completed notebooks to local high schools."

"Doctors' wives will take these notebooks to the guidance directors or school superintendents. These personal contacts will give us an opportunity to explain the need for nurses, the opportunities available, and the use of the notebooks," according to Mrs. Falk.

PBS
PROFESSIONAL BUSINESS SERVICE
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"BIRTH OF A BABY" BROADCAST HAS M. D. COOPERATION

Madison, April 20.—A public service radio program presented by the Dane County Medical Society in cooperation with a Madison radio station has received state and nation-wide recognition.

On March 22, Madison area radio listeners heard a 30 minute broadcast of the actual birth of a baby from the delivery room of a Madison hospital. This unusual documentary entitled "Birth of a Baby," was prepared purely as an educational feature designed to remove the fears and misunderstandings of many prospective parents.

Previewed by Critics

The idea for the program was presented to the Dane County Medical Society last fall by Dick Weiner, Madison free-lance writer, representing radio station WISC. The radio station guaranteed its full cooperation in order to bring this public service feature to the public.

The county medical society immediately endorsed the proposal and appointed a special committee with Dr. C. G. Reznichek, Madison, as chairman, to set up the program and handle details of the broadcast.

The State Medical Society and legal counsel assisted in the preparation of releases absolving the Medical Society, individual physicians and all parties concerned from liability for so-called "invasion of privacy" of the parties concerned.

It was a condition of the releases that the names of the patient, doctors in charge, and hospital remain unknown.

County Society Approved

During the delivery itself no non-medical people were allowed in the operating room. The only persons present were the mother, her obstetrician, the anesthetist, the physician who served as narrator and other professional persons.

The entire birth procedure—from the time the patient entered the delivery room until the cry of the new born child was heard—was tape recorded. During the birth, the physician serving as narrator described the scene and what was happening with reasons for the various procedures being performed by the physicians and hospital personnel. The original tape recording lasted 55 minutes, but was later cut to 30 minutes so that the program would be more understandable to the layman and in good taste.

Shown here with tape-recording preview of "Birth of Baby" broadcast are (L to R) Drs. M. J. Musser, C. G. Reznichek and J. R. Steeper. Seated is Dick Weiner, program director. Also on the Dane County Medical Society committee handling the project were Drs. Louis Fauerbach, R. S. Gearhart and G. H. Ewell, society president.

When radio station WISC decided that the program was in proper form, the Dane County Medical Society board of directors reviewed the program and made suggestions for final changes. When these were made, the broadcast was previewed by a group of specially invited guests representing clergymen, educators, press, radio, the Better Radio Listening League and the Madison Parent Teachers Association.

On March 22, after several months of preparation, the broadcast was presented as part of a series known as "Sounds of Science." The response of radio critics was immediate.

Wide-spread publicity was given to the program locally and write-ups appeared in Quick magazine, Chicago Sun Times and throughout the United States through the facilities of United Press.

Hospitals Admitting a Patient Every 2 Seconds

Chicago, May 9.—American Hospital Service last year reached an all-time high, according to a report of the Council on Medical Education and Hospitals of the American Medical Association.

The 6,637 hospitals registered by the council admitted 18,237,118 patients last year, or one every 1.7 seconds.

Governmental bodies—federal, state and local—controlled three out of every ten hospitals and provided seven out of every ten beds. However, three out of every four admissions were to non-governmental institutions.

The reason for this is that 55 per cent of governmental hospitals are of the general type, while 82 per cent of the non-governmental hospitals are organized for general care.

A study of the average length of stay in general hospitals shows that in 1951 the figures were 25.5 days in federal hospitals, from 10.4 to 14.6 days in state and local institutions, 8 days in non-profit hospitals and 5.8 days in proprietary units.

VA ISSUES NEW RULING ON EXAMINATION OF VETERANS FOR HEARING IMPAIRMENT

Madison, April 10.—A revised method of examining veterans to ascertain the extent of hearing impairment has been issued by the regional office of the Veterans Administration, Milwaukee, in a letter to the Wisconsin Veterans Medical Service Agency of the State Medical Society.

Fee basis physicians conducting such examinations for veterans are given the following instructions:

"Examinations utilizing controlled speech reception apparatus will, whenever practicable, replace examinations recording impaired hearing in terms of number of feet at which ordinary conversational voice is heard. . . .

"When such examinations are not practicable by reason of unavailability of apparatus, examinations will be on the basis of pure tone audiometry. . .

"When results of pure tone audiometry tests are used, reliance on only one audiogram for each ear is unsatisfactory; test results should be evaluated clinically, and repeated until the examiner is assured that the subject's response reflects familiarity with proper methods of responding to the sounds."

The VA said it presumes that controlled speech reception apparatus will not ordinarily be available to the fee basis examiner. Therefore, it requests examiners to provide VA with two audiograms for each ear, or if this is impracticable, to certify on the bottom of each audiogram: "I have rechecked this reading."

It is no longer necessary to record percentage of hearing loss on audiograms, the VA said.

GOING TO EUROPE THIS SUMMER?

Chicago, May 1.—Physicians planning a trip to Europe in the summer of 1953 may be interested in attending the First World Conference on Medical Education which will be held in London in August.

Persons interested in the meeting may contact Dr. Louis H. Bauer, Secretary-Treasurer, World Medical Association, 2 East 103rd St., New York 23, New York

17 M.D.s Named Civil Defense Team Captains

Madison, May 5.—Team captains have been selected for the civil defense area including the counties of Outagamie, Winnebago and Fond du Lac.

These physicians will be in charge of mobile medical teams of 29 persons each.

Team captains in this area are under the direction of Dr. J. S. Wier, Fond du Lac, an area medical co-director in Wisconsin state civil defense.

Physicians serving as team captains in this area are:

Drs. J. P. Canavan, Roger Henning, and John E. Conway, Neenah; George Hildebrand, Menasha; Simon Cherkasky, Kaukauna; W. S. Giffin, A. J. Gloss, and Milo Swanton, Appleton; Ruben H. Bitter, Stanley Graiewski, L. O. Helms, and Ray F. Wagner, Oshkosh; W. H. Schuler, Ripon; H. H. Howe, Waupun; and W. C. Finn, A. M. Hutter and R. L. Waffle, Fond du Lac.

More Priority I M.D.s Ordered to Duty

Madison, May 5.—A total of 232 physician officers of the Army Medical Service Reserve will be ordered to active military service in July, according to information received by the Wisconsin Advisory Committee from the Department of Defense.

Included in the group will be 85 physicians from the Fifth Army area which includes Wisconsin.

Priority II Dentists

These physicians are available, Priority I physicians who accepted commissions after being processed as selective service registrants.

Medical officers selected for this call-up will be ordered to active duty for a two-year period.

In addition, the Department of Defense is calling dentists with a Priority II rating. This is due to the fact that the listing of dentists available under Priority I has been exhausted.

Defense officials have advised that induction orders may be issued in September for physicians in Priority I who have been declared "available" but who have not yet accepted commissions.

EMERGENCY CARE PLAN PROPOSED BY RACINE COUNTY MEDICAL SOCIETY

Racine, Apr. 1.—The Racine County Medical Society has offered a plan which it believes will solve the problem of securing medical care and hospitalization for emergency cases, according to the Racine Journal Times.

Some time ago, Racine Fire Chief Rudolph Anderson reported to the society that his rescue squad was having "more and more difficulty in getting doctors to respond to emergencies when their services are needed."

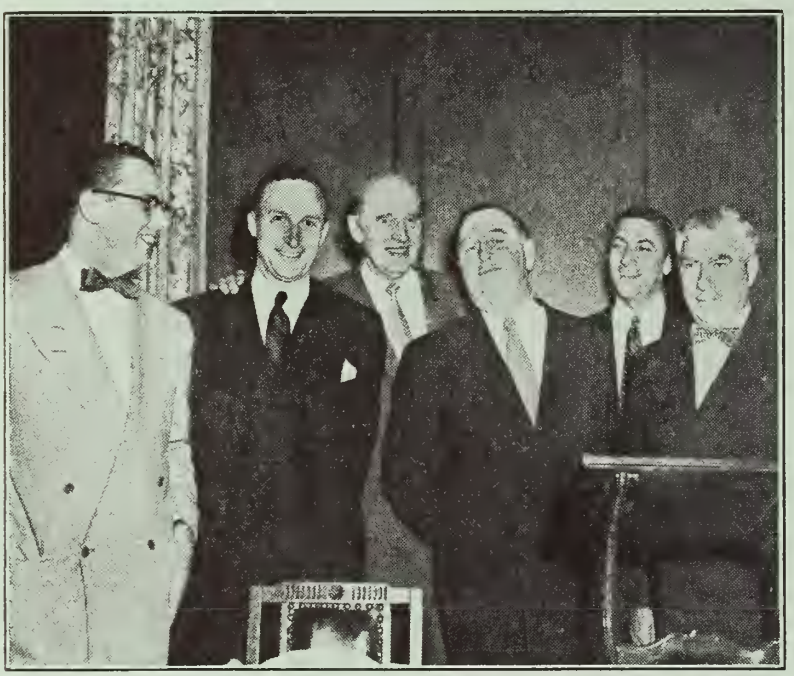
The new plan provides:

1. **Both Racine hospitals have emergency rooms for outpatients.**
2. **Patients can be transported directly to the emergency room of the hospital of the patient's choice on the judgment of the captain of the rescue squad.**
3. **The captain of the squad is to notify the hospital that a patient is coming and the hospital is to contact a physician —first, the family physician if there is one; second, a physician from a panel of staff doctors on a rotating emergency call set up by each hospital.**
4. **Patients will be hospitalized if a room is available, or sent home at the discretion of the physician.**

Dr. Beatrice Jones, chairman of the society's public relations committee, recommended that those individuals who want a doctor but do not believe the rescue squad is necessary should make every effort to contact their family physician.

The society is also recommending, Dr. Jones said, that each doctor handle his own emergency calls as much as possible or at least provide for a substitute in his absence.

If this fails, she added, the individual should call one of the hospitals which will make an effort to find a physician.



Speakers at the Milwaukee public relations forum were (L to R) Leo E. Brown, public relations director of the AMA, Chicago; J. H. Paige, vice president in charge of public relations, Wisconsin Telephone Company; D. H. Witte, M. D., moderator; M. J. Wegmann, M. D., president, Milwaukee medical society; Ben Barkin of Ben Barkin & Associates; and F. V. Birch, president, Klau-Van Pietersom-Dunlap Associates, all of Milwaukee.

PUBLIC RELATIONS SPECIALISTS OFFER ADVICE TO MILWAUKEE DOCTORS

Milwaukee, May 5.—Doctors should diagnose public opinion to find out how people feel about the medical care they receive if they want to improve relationships between patients and physicians and stave off compulsory health insurance.

Four advertising and public relations men gave this advice to nearly 250 members of the Medical Society of Milwaukee County at a forum on May 2.

Ben Barkin, president of Ben Barkin & Associates, urged a survey of public opinion to find out where physicians need to take immediate, constructive action to solve their most acute public relations problems. He urged greater publicity to society activities such as emergency telephone service, cancer detection, and blood bank work.

Although voluntary prepayment plans for medical care can be had by a majority of the population, he pointed out that there is still criticism of the profession by persons who claim that they can't get medical care because they can't afford it.

He suggested that one of the most effective methods a county medical society could use to end such complaints would be to announce publicly that physicians are willing to care for anyone day or night regardless of whether the patient has the means to pay for the treatment.

Leo Brown, public relations director of the American Medical Association, said that "only about 2% of the American doctors are unethical, but the whole profession is criticized because of them. They should be censored or kicked out of medical societies. If they aren't, any public relations program is bound to fail," he said.

Itemized medical bills were advocated by Frank V. Birch, president of Klau-Van Pietersom-Dunlap Associates, Inc. John H. Paige, vice-president of Wisconsin Telephone Co., urged doctors to start their public relations program with their employees. "A friendly, helpful nurse or receptionist can have a great deal of influence on a patient's feeling toward his doctor," he explained.

PRESS CONFERENCE AT MADISON—

(Continued from page 485)

close acquaintance between the reporter and the physician make the reporting of news much simpler for everyone concerned.

2. Hospitals need to establish a definite plan within each hospital for the handling of medical news through one or more responsible persons. Some hospitals have developed simplified "public information" forms by means of which reporters are given a "condition report" on any patients about whom they may inquire.

3. In speaking of accident cases, several editors said they were not interested in anything but condition reports—good, fair, critical, etc. Others want to know the extent of injuries. Usually newspaper men are quick to understand why certain information cannot be revealed, if the physician explains in a few words the reason for his reluctance to make public disclosure of such information.

4. A meeting of a special committee of editors with the Council on Medical Service might pave the way for the more immediate solution of press-medical problems.

5. The news value of new drug and treatment reports should be tempered by understanding of the gullibility of the credulous sick. In reporting such developments newspapers should recognize that all new drugs are not immediately available everywhere and should make this fact plain in such articles.

BULLETIN

Washington, D. C., May 6.—The full Senate Armed Services Committee has approved a bill which would extend from September 1, 1952 to July 1, 1953, authorization under which the armed services and public health service physicians and dentists would receive a special payment of $100 per month while on active duty. The effect of this is to separate the physician–dentist special pay issue from the question of incentive and hazard pay for other services. The Senate will now have an opportunity to vote on special doctor–dentist pay without reference to the other question.

Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

Hydrazides of Isonicotinic Acid in Tuberculosis

These agents, of which Rimifon and Nydrazide are typical examples, are so new that true assessment of their value is not yet possible. The following is merely a summary of what *seems* to be their present status.

Clinical Effects—Both subjective and objective improvement occur in most uncomplicated cases with caseous pneumonic lesions within a month, even though they may not have responded previously to streptomycin and PAS. Earlier pulmonary lesions often begin to respond in 5 to 7 days. There is striking curtailment of toxicity with rapid drop in temperature, improvement in appetite, and gain in weight. The improvement in sense of well-being at times approaches euphoria. Cough and expectoration are diminished or eliminated, and the acid-fast organisms in the sputum decrease and often disappear. Slight roentgenographic changes appear at the end of a month in the early pulmonary cases, but there is very little change in this regard in the advanced cases. Lesions of the mucous membranes (mouth, tongue, bowel), the larynx, cutaneous sinuses, and fistulas respond rapidly. The action is favorable in meningitis cases without resort to intrathecal therapy. Bone lesions and adenitis respond very slowly, empyema both slowly and poorly. Recorded experience in other types of tuberculosis has not yet come to my attention.

I have not seen published reports of the development of resistance to the drugs, but word has gone around that such resistance has been observed to develop in some instances as early as 26 days after the beginning of the treatment.

Nature of Action—In both *in vitro* and *in vivo* studies these drugs have exhibited tuberculostatic and tuberculocidal actions, and in some experimental infections their protective action has persisted after discontinuance of therapy. They have not shown chemotherapeutic action against experimental hemolytic streptococcal, pneumococcal, Salmonellal, trypanosomal, trichomonal or influenzal viral infections.

Absorption, Distribution, and Excretion—Absorption from the upper intestinal tract is rapid. A plasma titer of 1.3 to 3.4 micrograms per cubic centimeter is reached in 1 to 6 hours after a single oral dose of 3 mg. per kilogram. Much greater amounts than necessary to inhibit Mycobacterium tuberculosis *in vitro* reach the spinal fluid in individuals with tuberculous meningitis. In the few studies performed, it has been found that about 60 per cent of single oral doses are recoverable in the 24 hour urine specimen.

Administration—Daily dosage of 2 to 4 mg. per kilogram is recommended for patients with normal kidney function, the higher dosage being preferred for children and young adults, lower dosage for elderly individuals. Dosing is usually begun at 2 mg. per kilogram in all patients and increased after 4 to 7 days if desirable. Duration of therapy seems to depend entirely on individual circumstances. Total daily dosage is given orally in 3 or 4 divided doses, preferably after meals. Tablets of 50 mg., and a syrup containing 50 mg. per teaspoonful, are available. For intramuscular or subcutaneous administration, which seems rarely necessary, there is available a 2 cubic centimeter ampule containing 50 mg. of the drug.

Toxicity—Transient albuminuria and a few casts have appeared in some cases; also reversible slight lowering of the hemoglobin level. Weekly blood studies and urinalysis are certainly advisable. I have heard of no hepatic damage or appearance of reactions in the skin. Evidences of central nervous system stimulation are insomnia, hyperactive deep reflexes, and leg twitching. Constipation, difficulty in initiating micturition, and dryness of the mouth suggest some effect on the autonomic nervous system. A few patients have complained of headache, tinnitus, and visual disturbances, but I believe that deafness has not been observed. Dizziness has sometimes been associated with transitory slight hypotension.

It is thought that the belladonna (atropine-like), sympathomimetic (epinephrine-like), and antihistaminic (pyribenzamine-like) groups of drugs may aggravate the side-action. Possibly prostigmine will counteract some of them.—Harry Beckman, M. D.

ASSOCIATION FOR PHYSICAL AND MENTAL REHABILITATION TO MEET IN MILWAUKEE

The Association for Physical and Mental Rehabilitation will hold its sixth annual convention at the Hotel Schroeder, Milwaukee, July 8–12.

The convention program will be printed in the June issue of the Wisconsin Medical Journal.

Clinicopathologic Conference

Editors—W. A. D. ANDERSON, M. A., M. D., Marquette University School of Medicine, Milwaukee
and D. M. ANGEVINE, M. D., University of Wisconsin Medical School, Madison

PRESENTATION OF CASE*

First Admission: This white male was first admitted to Wisconsin General Hospital in 1938 at the age of 17 with the chief complaint of swelling in front of the right ear. Onset was first noted 9 months prior to admission with subsequent gradual increase in size.

Physical examination: The patient was well developed and well nourished. Over the right parotid area was a freely movable and non-tender 3 cm. mass. The lungs and heart were described as normal. Blood pressure was 135/80. The abdomen was scaphoid and negative on palpation.

Laboratory: A urinalysis was within normal limits. Hemoglobin was 15.6 Gm.; red blood cell count 5,590,000; and white blood cell count was 9,800, with 59 per cent neutrophils, 37 per cent lymphocytes, and 4 per cent monocytes. The blood chemistry and serology revealed no abnormalities.

Course: Treatment consisted of excision of two small tumors of the right parotid region. Following the report on the tissue sections, several small lymph nodes in the right axilla were noted, as well as a percussible but non-palpable spleen. After x-ray therapy the patient was discharged in good condition 10 days following admission with the recommendation to return in three months. He failed to reappear prior to the second admission.

Second Admission: The patient was readmitted on December 21, 1942 with recurrence and gradual increase in size of a mass near the right ear, first noted about one year following previous admission. No additional symptoms were elicited except for progressive diminution of auditory acuity, right.

Physical examination: General appearance was similar to that on initial admission. Just anterior and inferior to the right ear was a 2 cm. hard, non-tender, movable, discrete mass. Several small nodes posterior and inferior to the right ear were firm, non-tender, and discrete. Nodes were palpable in the left cervical area as well as a few small axillary and inguinal nodes bilaterally. The spleen was non-palpable. There was no mediastinal enlargement to percussion.

Laboratory: The laboratory findings were within normal limits as was chest x-ray. A lymph node was again removed.

Course: Treatment consisted of x-ray therapy. The patient was discharged in nine days and instructed to return.

*From the State of Wisconsin General Hospital and University of Wisconsin Medical School.

Interval History: In the succeeding eight years the patient was seen repeatedly in the outpatient department. The liver was first palpable 2 to 3 cm. below the right costal margin approximately one year following discharge; the spleen was first palpable six months later. Intermittent x-ray therapy was instituted in 1944 because of progressive splenic hypertrophy and increasing generalized lymphadenopathy. The white blood cell count varied from 7,000 to 13,000; red blood cell count and hemoglobin levels remained fairly stable between 4,800,000 and 5,700,000 cells and 15.0 Gm. and 18.0 Gm. The patient's weight remained fairly constant at a normal level of 145 to 155 lbs. In 1945–1946 gradual change in the blood picture to that of polycythemia of mild to moderate degree was noted. The spleen was palpable 4 to 5 cm. by that time, and the liver 3 to 4 cm. below the right costal margin. In 1948 macular and vesicular lesions appeared over the face, arms, trunk, and thighs. Local therapy was instituted for this with moderate success. Concurrently, the elevated red blood cell count and hemoglobin returned to normal; the white blood cell count dropped to 4,000 to 5,000.

In January 1950, slightly elevated, reddish nodules (1 to 2 cm.) were noted on the medial surface of the left arm. Purulent drainage from these lesions was noted at times. A few months later similar nodules appeared along the inner aspect of the left biceps plus a maculo-papular type of lesion on the dorsal aspect of both hands and forearms. Intermittent episodes of chilliness and fever were noted during the year preceding admission; night sweats were consistently present. Weight had gradually dropped to 130 from about 150 lbs.; hemoglobin 13.4 Gm.; red blood cell count 4,260,000; and white blood cell count 4,650. Three months prior to admission numerous brownish nodules and vesicular lesions were noted on both forearms. More frequent x-ray therapy was instituted at that time, but the prescribed course of therapy was not completed. Progressive loss of energy and anorexia appeared together with ulcerations of the buttocks, face, feet, and arms. Local therapy resulted in improvement of the lesions. Ulceration and drainage of purulent material from lesions of the right foot appeared about three weeks before admission, as did bilateral dependent edema plus additional lesions on the left thigh, both buttocks, and in the perianal region. Appearance in these areas coincided with objective improvement in the pre-existing lesions. Laboratory findings during the few months preceding admission included: hemoglobin 8.0 to 9.5 Gm.; red blood cell count 2,600,000 to 4,100,000; white blood cell count

3,500 to 4,000; and differential revealed a moderately elevated neutrophil count with later decrease corresponding with a relative increase in non-segmental forms. Lymphocyte average was 22 to 27 per cent, eosinophils 0 to 3 per cent, and monocytes 3 to 17 per cent. A "ruptured intervertebral disk" was said by the patient to have been removed elsewhere in 1949.

THIRD AND FINAL ADMISSION: The patient was readmitted on August 16, 1951 for further evaluation and therapy. At this time he was 30 years of age.

Physical examination: The examination revealed a temperature of 98.4 F., pulse 120, respirations 18, and blood pressure 120/68. The patient was thin and appeared chronically ill. He attributed his moderate physical discomfort to ulcerations on his lower extremities; otherwise, he had no subjective complaints. He was alert, cooperative, and oriented. The skin was pale and sallow. There were numerous brown-pigmented, circular, slightly elevated lesions over the arms, back, and chest. There was an area over the left face anterior to the ear, about 10 cm. in diameter, which was slightly elevated with an erythematous margin. This contained about 25 to 30 small, reddened, firm, sensitive, and slightly elevated, punched-out areas containing purulent-like material. There were two large ulcers on the left forearm 1 to 2 cm. in diameter with surrounding erythema. There was also a 2 to 3 cm. erythematous, fluctuant, tender mass on the left upper arm. There were similar ulcers over the ischial tuberosities and near the rectum. Smaller ulcers were present on the right calf, the sole, and the medial aspect of the right foot. Verrucae of the right hand were noted. Generalized lymphadenopathy included palpable auricular, cervical, suprascapular, axillary, and inguinal nodes; those in the axillae and inguinal regions being 3 to 5 cm. in diameter, firm and discrete; and those in the other areas were much smaller. Venous pulsation was visible in the neck. The trachea was in the midline; the chest was symmetrical. There was increased mediastinal dullness. The heart was not enlarged to percussion; there were soft systolic murmurs over the apex and base. The abdomen was tense and distended with a "doughiness" suggestive of mesenteric and retroperitoneal lymph node involvement. The liver extended midway to the umbilicus on deep inspiration, and the right diaphragm appeared elevated. The spleen was palpable 6 cm. in the midclavicular line. The general picture was one of marked toxemia and anemia, nutritional disturbance, and cutaneous infection.

Laboratory: Specific gravity of urine was 1.006 with a trace of albumin. A centrifuged specimen revealed 5 white and 2 red blood cells per 10 high power fields and 1 to 2 hyaline casts per low power field. The hemoglobin was 8.2 Gm., red blood cell count 2,320,000, and white blood cell count 2,800, with a differential of 64 per cent neutrophils, 21 per cent band cells, 10 per cent lymphocytes, and 5 per cent monocytes. The blood sugar was 82 mg. per hundred cubic centimeters, nonprotein nitrogen 41 mg. per hundred cubic centimeters, and total serum protein 3.3 Gm., with 2.4 Gm. albumin and 0.9 Gm. globulin. The Wassermann test was negative. Hematocrit reading was 25 per cent; sedimentation rate (uncorrected) was 15 mm. per hour. Coomb's test was negative; thymol turbidity, 2 units; Hanger's test, negative; prothrombin time, 52 per cent; and fecal urobilinogen, 160 mg. per 24 hours. Chest x-ray revealed minimal mediastinal adenopathy with slight widening of the mediastinal shadow, especially on the right, and also peribronchial infiltration bilaterally.

Course: Treatment included six blood transfusions of 500 cc. each during the two and one-half months of hospitalization. Antibiotic therapy included penicillin, chloromycetin, and streptomycin, administered orally or parenterally as indicated. During the first three weeks of hospitalization, the patient received five intravenous injections (6 mg. each) of nitrogen mustard—the interval between injections being determined by the daily white blood cell counts. The hemoglobin ranged from 10.6 to 12.2 Gm. The white blood cell count was consistently depressed between 2,500 and 5,500 except for a period during nitrogen mustard therapy in which it dropped to 1,200. The differential did not vary significantly. A biopsy was obtained from the skin at the edge of the suppurative lesion on the face and reported as a skin abscess of unknown etiology. Aspiration of purulent material from a skin lesion of the arm revealed numerous acid-fast organisms on smears. Cultures for tuberculosis bacilli, however, were reported as negative after eight weeks.

During the course of hospitalization several consultations were obtained with the Dermatology Department. The first consultation report indicated that the skin lesions were furuncular and not infiltrative; other observations at that time included herpes simplex of the left temporal area plus verrucae of the hands. The consultant recommended cultures for deep mycoses because of the possibility of generalized sporotrichosis; cultures were obtained for the aforementioned organisms plus repeat cultures for acid-fast organisms. Guinea pig inoculation was also requested. After two months therapy with the various antibiotics plus califerol, there was obviously no response to any of the agents which had been employed. The course was steadily downhill. Final evaluation about two weeks prior to death indicated that the skin lesions did not appear to be typically tuberculous but rather a superimposed infection upon a primary pyogenic dermatitis and that because of total lack of response to intensive antibacterial therapy, fungus infection should be considered and iodide therapy instituted prior to receipt of report of cultures. During the final week of hospitalization the patient became comatose and expired on the seventy-ninth hospital day.

Clinical Discussion

Dr. J. W. Brown: I do not know what caused the death of this patient. The remarks of some of my colleagues, who apparently have this knowledge, suggest that the complete diagnosis was not established during life. The course of this patient's illness does present a clinical pattern similar to that of certain chronic or subacute and ultimately fatal granulomatous infections and lymphoblastomas. The clinical course suggests that the condition was of long standing and involved many parts of the body. According to the history, it began when the patient was 17 years of age and persisted for 13 years before death, which occurred at the age of 31. The primary disease was not fulminating until shortly before death.

The final admission took place on August 16, 1951, and terminated in the patient's death after about three months. He was chronically ill on admission. Ulcerations of the skin had involved the forearm. Absence of pain over the splenic region suggests that inflammatory perisplenitis did not occur. Lymphadenopathy was most prominent in the upper extremities and cervical regions. There were venous pulsations above the sternum in the neck, but the trachea was in the midline. X-rays demonstrated only minimal enlargement of the mediastinum, presumably due to increase in size of hilar lymph nodes. A peribronchial infiltrative lesion extending from the hilum into the lung was visualized.

Dr. Wayne Rounds: X-rays taken in October 1949 were negative. The pictures taken at the time of the last admission showed a slightly widened superior mediastinum with a little more prominence on the right than on the left and a coarse linear density extending outward from the hilar areas. The diaphragms were slightly elevated bilaterally. The conclusions from this film were that there was a slight peritracheal lymphadenopathy and some peribronchial infiltration consistent with Hodgkin's disease.

Doctor Brown: Palpation of the abdomen was described as doughy. Accumulation of fluid in the abdomen is the more likely explanation. Dependent edema developed, perhaps in association with abdominal fluid. The cutaneous infection occasioned discomfort and probably contributed to the rapidly failing course.

The laboratory results obtained during the last admission are of importance. The specific gravity of the urine was low, 1.006. If present consistently, this indicates a fixed, low specific gravity and may mean a degree of kidney insufficiency. The blood nonprotein nitrogen of 41 mg. per cent supported this opinion. The centrifuged urinary sediment contained several white blood cells, 2 red blood cells per high power field, and 2 hyaline casts. Normochromic anemia progressed. Leukopenia became more pronounced with increasing numbers of white blood cells, not compatible with aplastic anemia. Abnormalities were demonstrated by tests of liver function. Reduction of total serum protein was the most significant. The prothrombin time was 52 per cent, indicative of liver damage in most cases. The Hanger's cephalin cholesterol flocculation test was normal. The thymol turbidity test was somewhat abnormal. This combination of liver function studies is frequently encountered in patients under the circumstances presented. The fecal urobilinogen noted here does not suggest a hemolytic process of importance.

Treatment in the hospital was not effective. Six blood transfusions were administered, presumably a supportive measure. The patient was given several antibiotic agents in sequence, probably for good reason and after consideration of the various complicating factors incident to the infection and to the specific agents employed. Nitrogen mustard therapy, administered by the intravenous route, had a temporary effect as manifested by the changes in red and white blood cell count. Another abscess in the skin developed, probably due to a pyogenic infection secondary to the debilitated state.

Tubercle bacilli were not identified at any time. Acid-fast bacilli were seen in smears. Acid-fast organisms which are found on direct smears from infected areas may not be tubercle bacilli. Differentiation depends upon cultural methods. The protocol notes several diagnostic possibilities suggested by consultants during the patient's life. Fungus infection was seriously considered, and a search was made for fungi as for tubercle bacilli. The results of these attempts are not indicated. The patient became comatose during the final week of hospitalization. Systemic dissemination by pathogenic fungi not infrequently involves the central nervous system. However, a patient may become comatose toward the end of any prolonged wasting disease.

The differential diagnosis in this case presents difficulties. There are certain aspects of the problem which suggest one cause and other features which suggest a second. The reaction to tuberculin is unknown. A negative reaction would have been helpful to eliminate tuberculosis. The sequence of events of this illness would seem to be explained most readily by a lymphoblastoma, most likely Hodgkin's disease, because of the age of the patient, the character of the clinical course, and the initial response to x-ray therapy. Hodgkin's disease can be associated with an identical illness and even produce the skin lesions noted. It is doubtful that Hodgkin's disease accounted for all of the symptoms and signs, but it is high on the list of differential diagnostic possibilities for the primary cause of the illness. Hodgkin's disease often begins with cervical, post or pre-auricular adenopathy, although the latter is infrequent. Persistence of cervical adenopathy for a period of years is common without demonstrable lesions elsewhere, particularly when x-ray therapy is administered. Many patients survive for as long as 13 years. Splenomegaly usually occurs eventually followed by enlargement of the liver. The spleen of this patient was percussible when he

was first examined. Hodgkin's disease can give rise to minute infiltrations which involve all parts of the body, similar to miliary tuberculosis. It may become manifest by abnormalities of any organ. This could account for the diminution of hearing and involvement of the spine experienced by this patient. The latter is more common in Hodgkin's disease. In many cases of this condition the patient remains well for a period of some years unless a fulminating type occurs. The total red and white blood cells in the peripheral blood are usually within normal limits, but an increase in each may be found at some stage. Later, progressive anemia and leukopenia usually develop. A similar sequence of events was described in the patient under discussion.

The presence of the type of extensive involvement of the skin in this case is unusual in Hodgkin's disease. The absence of itching and the degree to which ulceration and purulent discharge occurred are against it. Tuberculosis is a chronic granulomatous infection which may have symptoms and signs identical to Hodgkin's disease. Differentiation is not always possible. Primary localized lymph node enlargement frequently is due to tuberculosis. The preauricular area is involved more often than in Hodgkin's disease. The nodes are usually discrete, non-tender, not attached to the skin and, in fact, distinguishable only by biopsy from lymphoblastoma or other chronic granulomatous diseases such as those due to fungi. Tuberculous nodes may become matted together, attached to the skin, and discharge purulent material at a later stage. This does not always take place. Generalized dissemination involving many organs including the liver and spleen may occur by lymphogenous or hematogenous routes. Progressive diminution of hearing in one ear may be due to tuberculosis. Sometimes enlargement of the spleen dominates the clinical picture. This condition is often associated with relative polycythemia, perhaps more uniformly when present than other conditions of the spleen except polycythemia vera. Anemia usually ensues ultimately, or anemia may predominate throughout. When tuberculous splenomegaly is a major feature of the clinical picture, there is usually generalized or at least extensive localized active tuberculosis elsewhere as well. Skin lesions of the ulcerating discharging type and distribution described in this patient are more readily explained by tuberculosis than by Hodgkin's disease. Finally, these two conditions are associated in many instances, but the relationship between them, if any, is unknown. The trend is away from attaching a similar etiologic significance to each.

There are several pathogenic fungi which may cause a pathologic process and present a course of illness to the clinician which do not differ essentially from that desribed. It is frequently impossible to identify the responsible agent without appropriate cultures. Certain considerations are against the fungus etiology, the most important of which are the rarity of such widespread involvement and the duration of the disease. Sporotrichosis was suggested. It is not likely to cause such an extensive process. Histoplasmosis is a possibility, but skin lesions of the type described are uncommon. Sarcoidosis can duplicate most of the findings presented, but the nodules of Boeck's sarcoid do not ulcerate to my knowledge. Histologic and cultural examinations will be necessary to differentiate for my complete final diagnosis in this case.

Dr. D. M. Angevine: The ward diagnosis at the time the patient came to our service was that of Hodgkin's disease on the basis of the biopsy. The skin lesions had never been accurately determined, but there were many suggestions as to the nature of the skin lesions, and since Doctor Johnson is aware of what was found at the autopsy table, we will not call on him until after we have presented the autopsy findings. Are there any more suggestions as to the diagnosis? Coccidioidomycosis and leprosy have been suggested.

Necropsy Findings

Dr. F. S. Jones: At autopsy there were only two features of importance noted on the external examination. One was the marked emaciation and the other, of course, was the skin lesions that have previously been mentioned. We noted the skin lesions particularly on the extremities and in the region of the head. The peritoneal cavity contained 200 cc. of a very clear yellow fluid. The heart and lungs were essentially normal. Lymph nodes throughout the body were not markedly enlarged; however, some tracheobronchial lymph nodes were found that measured as much as 1.5 cm. in diameter, and some mesenteric lymph nodes measured up to 1.0 cm. in diameter. The liver was a little enlarged, weighing 1,800 Gm., and contained many scattered yellowish gray nodules throughout. The kidneys were about normal weight, but they too contained nodules. There were miliary sized yellowish white nodules throughout the kidney parenchyma. The spleen weighed 850 Gm. which is about 5 times normal. The splenic pulp was very firm to palpation, and there was a grayish mottling or nodulation throughout the splenic parenchyma.

The skin biopsy taken during life included the epithelial surface and the boundary of a definite abscess. The cells in the area were almost entirely polymorphonuclear neutrophil leukocytes. An acid-fast stain of the skin section revealed myriads of acid-fast bacilli. In addition, the skin obtained at autopsy showed occasional round, budding, yeast-like forms.

A low power view of the first lymph node removed in 1938 showed quite a marked distortion of the architecture. Closer inspection revealed many large mononuclear cells scattered among the lymphocytes of the node. These cells were indeed quite large and had very prominent nucleoli and a very heavy nuclear membrane. Some of them appeared to have multilobed nuclei. I think that the picture here was entirely consistent with that of Hodgkin's disease.

A low power view of the lymph node removed in 1942 showed essentially the same pattern as that seen in the earlier biopsy. The picture of Hodgkin's disease here was similar to the paragranuloma type described by Jackson and Parker.

The tracheobronchial lymph node from the autopsy had two distinct lesions. There was a cellular area of Hodgkin's disease, and the peripheral sinus was quite dilated and contained very large giant cells along with many eosinophilic rounded organisms which frequently were budding. Morphologically, these were Cryptococcus neoformans or torula. A low power view of the lung again showed the budding forms which seemed to be surrounded by a lighter area suggesting a capsule situated in the alveolar walls of the lung, but the alveoli themselves contained no exudate.

In the liver there were two lesions, one of which was a rather non-cellular lesion containing the torula, and the other was a very cellular area which also showed many Reed–Sternberg cells. Fibroblasts, large mononuclear cells, and lymphocytes were also present, but not eosinophils. Microscopically, the spleen contained two lesions, one was a cellular area with considerable hyaline and the other was foci of budding fungus forms (Fig. 1). Note that around the organisms there was practically no cellular reaction. Throughout the liver and spleen one notices that the areas of Hodgkin's disease were associated with much hyaline material. This certainly suggests considerable healing of these lesions may have taken place.

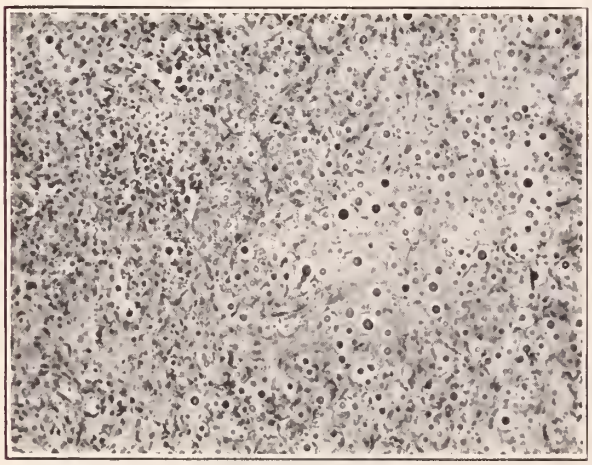


Figure 1.

The adrenal gland showed foci containing budding yeast-like forms. The kidneys presented scattered foci microscopically which contained the cryptococci. Frequently glomeruli contained budding forms, but also some of the tubules contained organisms. A Shiff's periodic acid stain brought out the budding better than some of the other stains. One certainly cannot help but think that the urine of this patient must have contained these organisms.

The bone marrow was very hypocellular. In areas the marrow cells had been completely wiped out.

Anatomic Diagnosis

Hodgkin's disease involving spleen, liver, and lymph nodes.

Cryptococcosis involving lungs, spleen, liver, pancreas, adrenals, kidneys, lymph nodes, and skin.

Doctor Angevine: The morphology in this case suggests that the x-ray therapy played a considerable role in keeping this man alive because we see areas of hyalinization in the spleen which suggest that the x-ray was effective in controlling the lesions to some extent. On the other hand we know that the paragranulomatous type of this disease is the one that progresses for longer periods of time than others, sometimes offering considerable difficulty in diagnosis from lymphoblastoma so that pathologists frequently suggest a diagnosis of lymphoblastoma instead of early Hodgkin's, but after the patient has been visiting the doctor for 10 to 15 years, one wonders why the patient does not die from lymphosarcoma. In this case I believe the terminal involvement with torulosis and acid-fast bacilli were both entirely different types of infection. They are unrelated and have occurred in an individual whose resistance is low.

Dr. Sture Johnson: When this patient was first seen by me in the Outpatient Department, a diagnosis of Hodgkin's disease had already been made. He appeared pale and cachectic. I felt that the various abscesses and furuncles which were present were those often seen in patients with terminal states of various diseases including Hodgkin's disease. The patient responded fairly well to wet compresses and topically applied antibiotics like bacitracin.

In the hospital various antibiotics were given orally and by injection. Wet packs of neomycin and of other medicaments were used with poor results. A diagnosis of tuberculosis of the skin was suggested by another observer. In my opinion, none of the skin lesions were characteristic of tuberculosis. The only skin lesion of tuberculosis that one might have considered was scrofuloderma. The others, like papulonecrotic tuberculids, lupus vulgaris, and erythema induratum, were definitely out. When the laboratory reported that acid-fast bacilli were present, calciferol or vitamin D_2 along with streptomycin was given since these two drugs have proven to be useful both in systemic and cutaneous tuberculosis. When no change in the patient's skin followed several weeks of this treatment and since there had been no change with other antibiotics, I suggested that we might be dealing with a deep mycosis-like sporotrichosis which at times may be generalized. You no doubt know that sporotrichosis histologically is a granuloma in which the causative agent cannot be demonstrated with ease, if at all, by hematoxylin-eosin stain. Several sections of the skin revealed a non-specific granuloma. Cultures for a deep mycosis on Sabouraud's media were negative. This tended to rule out the diagnosis of sporotrichosis since it is usually fairly easy to isolate.

The close association between a torulosis and Hodgkin's disease has been emphasized often in the literature. Does Hodgkin's disease weaken the patient so he becomes a candidate for torulosis, or does torulosis cause a picture of Hodgkin's disease? Animals inoculated with Torula histolytica have developed lesions which histologically were characteristic of Hodgkin's disease.

These laboratory observations, as well as those found in this patient, should alert us to the fact that Hodgkin's disease may be simulated by conditions like torulosis.

Doctor Angevine: Before and at the time of autopsy Doctor Piper did considerable culture studies and investigation on this patient and looked up the relationship of various fungus infections to Hodgkin's disease.

Doctor P. G. Piper: With the limited time remaining I will briefly tell what we did. First, we obtained material from the deep skin lesions and on culture found torula, only after extensive work, however. The organism failed to form the capsule, and finally by inoculating a saline suspension intra-abdominally into a mouse, we were able to obtain the capsular form at postmortem. This is well illustrated by the India ink preparation. (Fig. 2) You can see the budding form of the Cryptococcus neoformans with the large capsule. Another slide was prepared from a plain agar plate which did not contain antibiotics, so often used in the preparation of mycelial cultures, which illustrated the acid-fast organisms fulfilling at least part of Koch's postulates. The gram positive forms which were seen in the background, we have felt, to date at least, to be a contaminant in this culture material. Whether it was introduced from the lesion or

Figure 2.

whether it was introduced from the laboratory we are not able to determine. To date, guinea pig and rabbit inoculations have been done. The rabbit and guinea pig at postmortem revealed no evidence of systemic infection or ulceration at the inoculation site, and since the organism did grow on plain media, Sabouraud's as well as the special media used for the reproduction of the human tubercle, and did grow at room temperature, we have felt that this was a non-pathogenic form of an acid-fast organism. Avian and bovine acid-fast forms, we feel, have also been ruled out. In the literature, of course, many are listed. The differential diagnosis in many instances is difficult. We are still working on the identification of the organism. It could be Mycobacterium lacticola or Mycobacterium phlei which are common contaminants. We do not know whether the organism itself played a part in the ulcerative lesions of the skin or as a secondary invader following the infection with the torula. We have identified both and are still attempting to name the acid-fast organism. As far as a brief review of the association of various types of infective agents as the etiologic source for Hodgkin's disease the literature itself can be summarized quite briefly. It is one of incidence, coincidence, and confusion because in the literature I have consulted, about 80 journals and articles written by men in the investigative field, everything has been blamed from the diphtheroid to the avian tubercle bacillus and recently brucellosis melitensis has been associated with Hodgkin's disease. Grand (Anderson's Pathology) has found cytoplasmic inclusion bodies upon the culture of involved material in the large Reed–Sternberg cells of the Hodgkin's granuloma—to prove an association and a virus as the etiologic cause. However, in a study of the Cryptococcus neoformans and its association with Hodgkin's disease, there is a very fine article by Gendel, Ende, and Normal[1] in which they have summarized 165 cases of the disease itself associated in 14 instances with Hodgkin's disease. Of the 14 cases of Hodgkin's disease, they reviewed six previous biopsies taken at the time of the initial diagnosis, and in 3 of these cases found Cryptococcus neoformans present. The authors, as well as others, have attempted to correlate this as a possible etiologic agent for this typical type of granuloma and have summarized their work quite well along with the other investigators in the field as the cause or the associated cause of this granuloma. Investigators have proposed the question, is there such a true entity as Hodgkin's disease or is it merely a histologic pattern, a reflection of various types of systemic infection? Benham[2] feels to the contrary that it is merely an association coincident with a long debilitating condition such as Hodgkin's sometimes presents. In these cases reviewed one finds the presence of the torula organism introduced and in other cases the acid-fast, so they feel that it is just an associated infective process that is superimposed on the original Hodgkin's disease. Fitchett and Weidman[3] have attempted to reproduce in experimental animals the granulomatous type of lesion simulating Hodgkin's disease. They have used the mouse, the monkey, cat, guinea pig, and rabbit; however in only one instance in a search for similar lesions simulating Hodgkin's disease in one cat on intrameningeal inoculation of tremendous doses of Hodgkin's diseased tissue did they finally get what

they considered to be the true granulomatous type of Hodgkin's minus, the Reed–Sternberg cells. There was a difference among the pathologists as far as the investigation was concerned, however. The final report which I think might be of interest to you concerning the relationship of Hodgkin's disease to reticuloendothelial type of infections was brought out also in a recent article in which a group of investigators[4] found in 241 cases of reticuloendothelial diseases the presence of torula in 49 such cases. They summarized their results as 16 found in the true Hodgkin's, 1 found in the lymphosarcoma, 3 found in leukemia, 5 in sarcoid, and 24 cases associated with acute generalized lymphadenopathy.

That leaves us then very briefly, with the possibility that Hodgkin's disease can often be associated with or have superimposed upon it a Cryptococcus neoformans. I think Jackson and Parker reporting in the Oxford University Press, 1947, so aptly put it: "The association of two uncommon diseases (torula and Hodgkin's disease) occurs much too frequently to be simply a matter of chance!"

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MILWAUKEE ACADEMY OF MEDICINE SPONSORS ESSAY CONTESTS

Two essay contests are being sponsored by the Milwaukee Academy of Medicine again this year—the Horace Manchester Brown Memorial Prize Essay Contest and the Rogers Memorial Prize Essay Contest, the latter founded by the Rogers Memorial Sanitarium of Oconomowoc.

In the Horace Manchester Brown Memorial contest, the Academy offers prizes of $100 and $50 for the two best scientific essays in any field of medicine, surgery, or the allied specialties. The essays need not represent original investigation but should represent individual work and must not have been previously published.

The contest is open to all physicians who have been graduated from medical school within the past ten years and who are residing in the state of Wisconsin or who are in the Armed Forces at the time the essay is submitted. Physicians who have been discharged from the Armed Forces and who have been graduated for more than ten years may submit essays if deduction of their period of service will bring them within the above mentioned ten year period following graduation. Awards will be determined by judges selected by the committee and will be presented at the annual meeting of the Academy of Medicine. Winning essays will be read at subsequent meetings.

Prizes of $200 and $100 will be offered in the Rogers Memorial contest, for the two most meritorious studies in the fields of neurology, psychiatry, and psychosomatic medicine. The contest is open to all members of the medical profession who are citizens of the state of Wisconsin, whether they are actually in residency or not, and to those who, not ordinarily residents of the state, are stationed in Wisconsin in the Armed Forces. Awards will be determined by judges selected by the committee and will be presented at the annual meeting of the Academy of Medicine. Winning essays may be read at subsequent Academy meetings and must be placed on file in the library of the Rogers Memorial Sanitarium, but may be submitted for publication (with proper acknowledgment) at the discretion of the author or the Rogers Memorial Sanitarium.

In both contests, all papers must be submitted in triplicate and double spaced. They should be sent to the office of the Milwaukee Academy of Medicine, 561 North Fifteenth Street, Milwaukee 3, Wisconsin, not later than December 1. The committee reserves the right to withhold the awarding of prizes if in its judgment no papers worthy of award have been submitted.

COMMITTEE *Concentrates*

CLAIMS COMMITTEE OF COMMISSION ON PREPAID PLANS

APRIL 3

MDs Present: C. G. Reznichek; N. A. Hill, J. S. Supernaw (substituting for J. T. Sprague).

Work begun on revising, coding, and additions to the master fee schedule. Staff authorized to assign proper code number, retaining in so far as possible the former code designation. Ten special cases involving fees reviewed, and decisions rendered.

SUB COMMITTEE OF MATERNAL AND CHILD WELFARE

APRIL 5

MDs Present: Amy Louise Hunter, L. M. Simonson, Thomas Leonard. F. J. Hofmeister, Gordon Schulz, and E. H. Pawsat.

Preliminary steps taken to set up a program to evaluate circumstances related to all maternal deaths in the state . . . this to be a joint project of the Committee on Maternal and Child Welfare, the Bureau of Maternal and Child Health of the State Board of Health, and the Wisconsin Society of Obstetrics and Gynecology . . . Need shown to have ultimate study concern itself with neonatal deaths more than maternal deaths, but preliminary study expected to limit itself to smaller mortality field. . . . Final recommendations as to form, method of carrying on study, and so forth, to be made to Committee on Maternal and Child Welfare at May 10 meeting. Then, if approved, will be reported to Council to carry out recommendations of 1952 House of Delegates.

INTERIM COMMITTEE OF THE COUNCIL

APRIL 12

MDs Present: A. H. Heidner, J. C. Griffith, R. G. Arveson, and J. M. Bell.

Approved insert in Journal on facilities to the blind in Wisconsin. . . . Approved proposal that issue of "Health" by State Board of Health be devoted to the various activities of the State Medical Society. . . . Appointed J. S. Devitt as advisor to Marquette University School of Medicine chapter of the Student American Medical Association. . . . Requested that steps be taken to interest the State Bar Association and the association of certified public accountants to study problems related to business services to professional persons, and to set up standards for regulation and supervision of this type of service.

COMMISSION ON PREPAID PLANS
Blue Cross Committee

APRIL 19

MDs Present: E. M. Dessloch, R. E. Garrison, P. B. Mason, and H. E. Kasten.

Reviewed Agency Contract between the State Medical Society and Associated Hospital Service, Inc. . . . Approved proposal that Blue Cross–Blue Shield programs be presented before county medical societies and hospital staff meetings. . . . Doctors Dessloch, Mason, and Garrison named to Blue Cross–Blue Shield Conference Committee.

Executive Committee

APRIL 23

MDs Present: E. M. Dessloch, J. S. Supernaw, H. E. Kasten, and Robert Krohn.

Recommended consideration to preparation of bi-monthly bulletin on Blue Shield for membership, hospital superintendents and boards of trustees, Wisconsin Plan carriers, Blue Cross executives and salesmen. . . . Approved IBM writing of vouchers in payment of WPS claims to replace manual operations. . . . Cleared several matters in connection with physician participation in the new programs relating to nonmembers, disabled and retired physicians, and restricted participation. . . . Various details resolved with respect to implementing sale of the new program.

Claims Committee

APRIL 23

MDs Present: C. G. Reznichek, N. A. Hill, and J. T. Sprague.

One of the problems the Claims Committee is considering is concurrent services of medical care and minor surgery on the same day in the hospital. Evaluated 23 problem cases.

CIVIL DEFENSE

APRIL 24

MDs Present: M. J. Musser, E. A. Bachhuber, K. E. Lemmer, and R. S. Baldwin.

Completed plans for preparation of material to be used in special "Civil Defense" issue of *Wisconsin Medical Journal,* scheduled for June publication.

COMMITTEE ON CANCER

APRIL 26

MDs Present: A. R. Curreri, R. P. Welbourne, P. B. Blanchard, G. L. McCormick, J. W. Conklin, W. D. Stovall, and C. N. Neupert.

Primary consideration given to improved methods of carrying on cancer education program to physicians. Recommended that during next year efforts be made to have leading hospitals in state have one staff conference solely on cancer, with a consultant furnished by the Wisconsin Division of the American Cancer Society. Teaching personnel to be secured from Wisconsin Society of Pathologists and others who are especially concerned with cancer problem . . . recommended to Wisconsin Division of American Cancer Society that it renew grant of $18,000 per year, for three year period, to McArdle Memorial Institute.

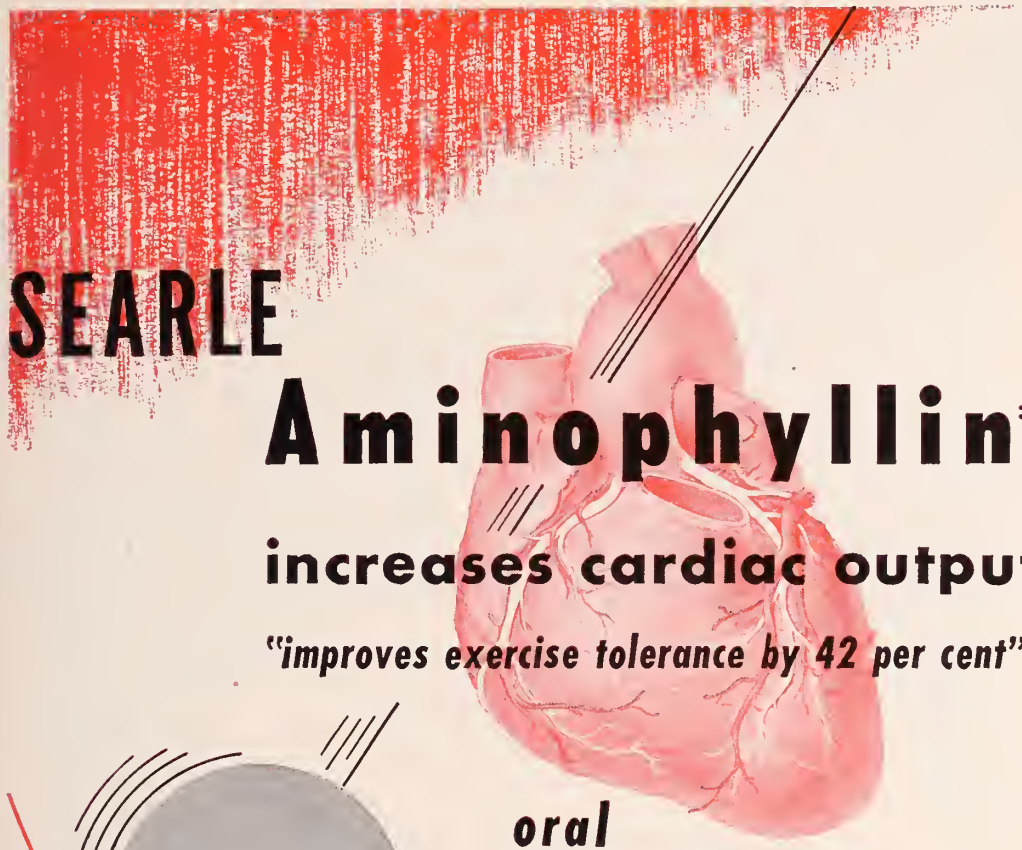
COMMITTEE ON GRIEVANCES

APRIL 26–27

MDs Present: E. D. Sorenson, C. E. Zellmer, F. A. Nause, H. W. Wirka, E. W. Mason, A. H. Heidner, and H. E. Kasten.

RELATED ACTIVITIES

On April 8 a special meeting of the Hearing Society Committee of Dane County held at SMS headquarters to lay plans for a coordinated hearing program in that part of the state. Doctor Charles Taborsky is medical advisor to the group interested in the program. . . . Important staff conference of Blue Cross–Blue Shield held in Madison on April 22 to iron out certain misunderstandings on development of sales program, and to revise the time schedule on mass publicity in connection with the new fee schedule and alternate coverage. . . . On April 22 a very significant conference of Welfare District Supervisors held at SMS headquarters to air certain problems relating to medical care features of public assistance program. This is a preliminary meeting to a joint conference with Society officials and a special Committee on Public Assistance Aids, where further consideration will be directed to medical phases of welfare programs. . . . Successful "Spring Clinics" were held at Richland Center, Chippewa Falls, and Merrill on April 22–23–24, with combined attendance at around 150 physicians. Teachers were Walter Blount, Milwaukee; E. S. Gordon, Madison; William Keettel, Iowa City, and Horace Korns, same address. It was sort of a "homecoming" for Doctor Keettel, who was formerly associated with the Bureau of Maternal and Child Health of the Wisconsin State Board of Health. . . . The MD–Press–Radio Conferences got off with a "bang" with an excellent meeting in Sheboygan on May 1. Over 70 doctors, editors, and radio station directors were in attendance. The conference was preceded by a meeting of the Council on Medical Services and Public Relations, where plans were made to direct more publicity to the expanding program of the "March of Medicine," to distribute widely an attractive "First Aid Guide" suitable for affixing to medicine cabinets in homes, factories, and schools, and approved a report on the Industrial Health Clinic program. . . . On April 25 the executive committee of the Wisconsin Division of the American Cancer Society met at SMS Headquarters. Doctors A. R. Curreri, W. D. Stovall, and Warner Bump were in attendance. It set up a retirement plan for employees, recommended the appropriation of $18,000 per year for three years, to support research at McArdle, and approved a new policy in relation to Community Chest participation. The Executive Committee works in close cooperation with the Committee on Cancer of the State Medical Society, which serves as the Medical and Scientific Committee of the Cancer Society. . . . May is full of committee meetings, teaching clinics, and special conferences.



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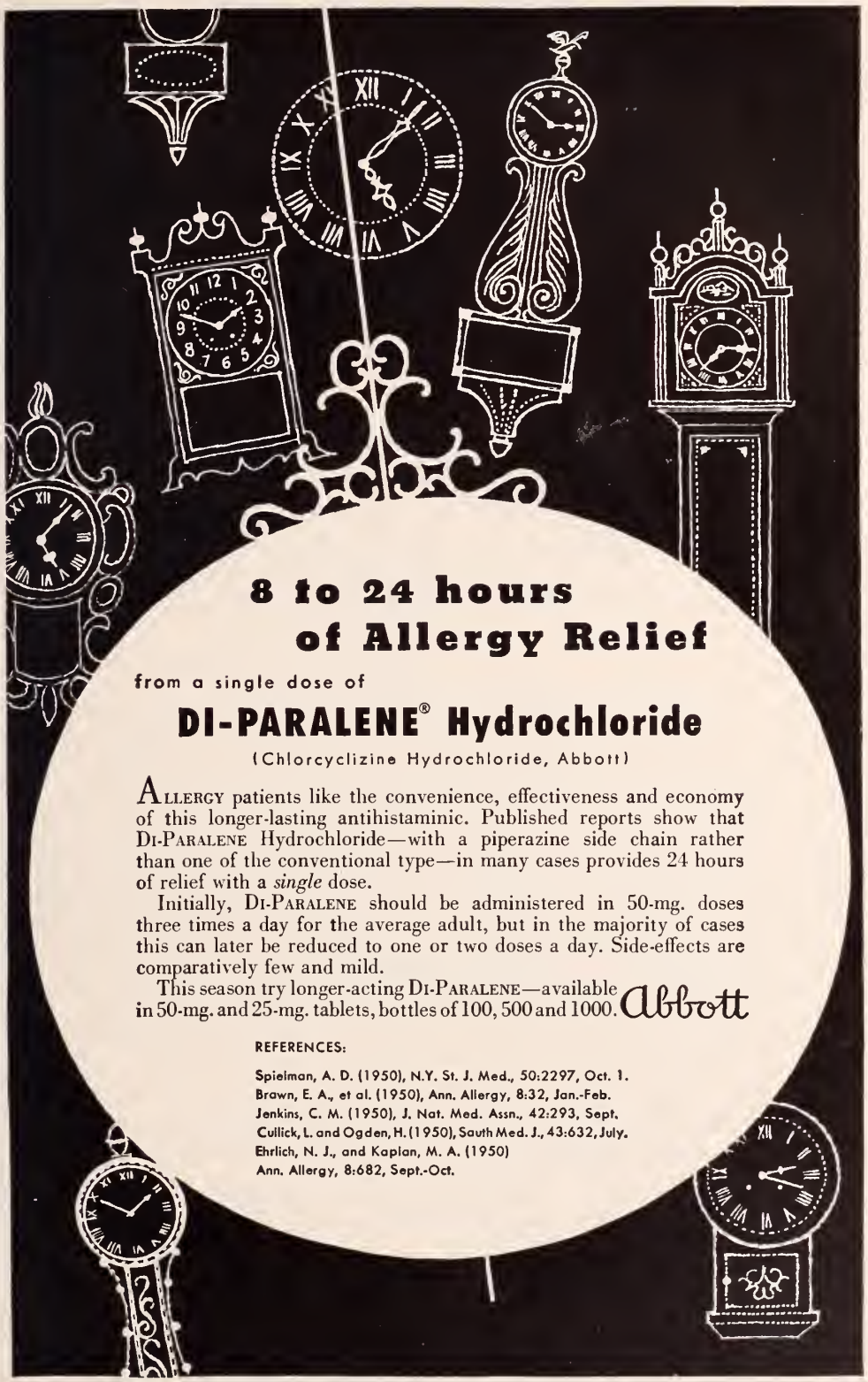
Prepared by the Commission on Prepaid Plans of the State Medical Society of Wisconsin,
E. M. Dessloch, Prairie du Chien, Chairman.

AN OUTLINE COMPARISON OF THE NEW WISCONSIN PHYSICIANS SERVICE PROGRAM

Provision	Present Contract	New Schedule "B" Plan	New Schedule "A" Plan
Surgery	Wherever performed	Wherever performed	Wherever performed
Surgical Fees for single procedures	Up to $150.00	Up to $200.00*	Up to $300.00*
Medical Coverage in Hospital (for Non-Surgical Hospitalization)	Provides up to 10 days per **Contract** year and payments begin on the **4th day** of each admission. Payable at $3.00 per day.	Provides up to 30 days per disability. (Separated by 60 days between hospital admissions for the same disability.) Payments begin on **1st day** of each admission. **Payable** at rate of: $8.00 for first day $4.00 for second and third day $3.00 thereafter.	Provides up to 30 days per disability. (Separated by 60 days between hospital admissions for the same disability.) Payments begin on **1st day** of each admission. **Payable** at rate of: $10.00 for first day $ 5.00 for second and third day $ 4.00 thereafter.
Anesthesia Services Associated with Surgery or Maternity Services	Payable if provided by a physician not in charge of the case and not by a salaried employee of the hospital.	Payable if performed and billed by a physician. (No other limit)	Payable if performed and billed by a physician. (No other limit)
	Patient must be in hospital.	Payable in or out of a hospital.	Payable in or out of a hospital.
	Amount: Less than ½ hr. $ 5.00 ½ to 1½ hr. $10.00 Over 1½ hr. $15.00	Amount: First ½ hr. $10.00 Each added ½ hr. $ 5.00 Maximum $25.00 (max. 2 hrs. per operation)	Amount: First ½ hr. $15.00 Each added ½ hr. $ 7.50 Maximum $37.50 (max. 2 hrs. per operation)
		T & A's—$10.00 maximum	T & A's—$15.00 maximum
Radiology Services Associated with Surgery or Maternity Services	Provided to the amount of $35.00 **per contract per year.** Must be performed outside of a hospital.	Provides up to $35.00 **per participant** per **disability.** Payable when performed and billed by a physician or surgeon. May be performed anywhere.	Provides up to $50.00 **per participant** per **disability.** Payable when performed and billed by a physician or surgeon. May be performed anywhere.
Dependents	Husband or wife and unmarried children between **30 days** and 19 years of age.	Same except new born is covered after **14 days** of age.	Same except new born is covered after **14 days** of age.
Full Payment Provision	Provided that participating Doctors would accept benefits as full payment if subscriber's income level was: $2000 annually for unmarried persons $3600 annually for married, including dependents' income.	Subscribers without dependents up to $2000 annual income. Subscribers with dependents up to $3600 annual income, including dependents' income.	Subscribers without dependents up to $3000 annual income. Subscribers with dependents up to $4800 annual income, including dependents' income.
Waiting Periods	Unless waived . . . provides 9 mo. waiting period for T & A's and other unstated pre-existing conditions.	Unless waived or previously served, 9 mo. waiting period for T & A's, varicose veins, benign tumors, hemorrhoids, cystocele or rectocele, indirect hernia, prostatic conditions, and pre-existing conditions known to the participant.	Unless waived or previously served, 9 mo. waiting period for T & A's, varicose veins, benign tumors, hemorrhoids, cystocele or rectocele, indirect hernia, prostatic conditions, and pre-existing conditions known to the participant.

* Formulas for specified multiple and multiple-stage procedures provide payments up to $500 and $700, depending on procedures.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. . . . THE PRESIDENT'S PAGE . . . .

Doctors Meet the Press

OUR first Medical–Press Conference was held at Sheboygan on May 1. It was attended by 70 physicians, newspaper editors and reporters, radio station managers, hospital personnel, and representatives of several police and sheriff's departments.

Most gratifying to me was the number of physicians who attended. Many of them had personally invited their local editors and radio men and brought them to the meeting. This is the spirit which will make these meetings successful, and I hope that it will continue throughout the state as the Medical–Press Conferences are held in other communities.

Discussion was free and frank. Everyone was seriously interested in clearing up the difficulties which are encountered in transmitting information concerning accidents and sickness to those whose business it is to present such news to the public.

The newspaper and radio men said they do not desire information that will disturb the physician–patient relationship or cause the physician to reveal facts which are confidential or restricted by legal or ethical considerations. They are primarily concerned with knowing the seriousness of the patient's condition, and, secondarily, with facts about the nature of the injury.

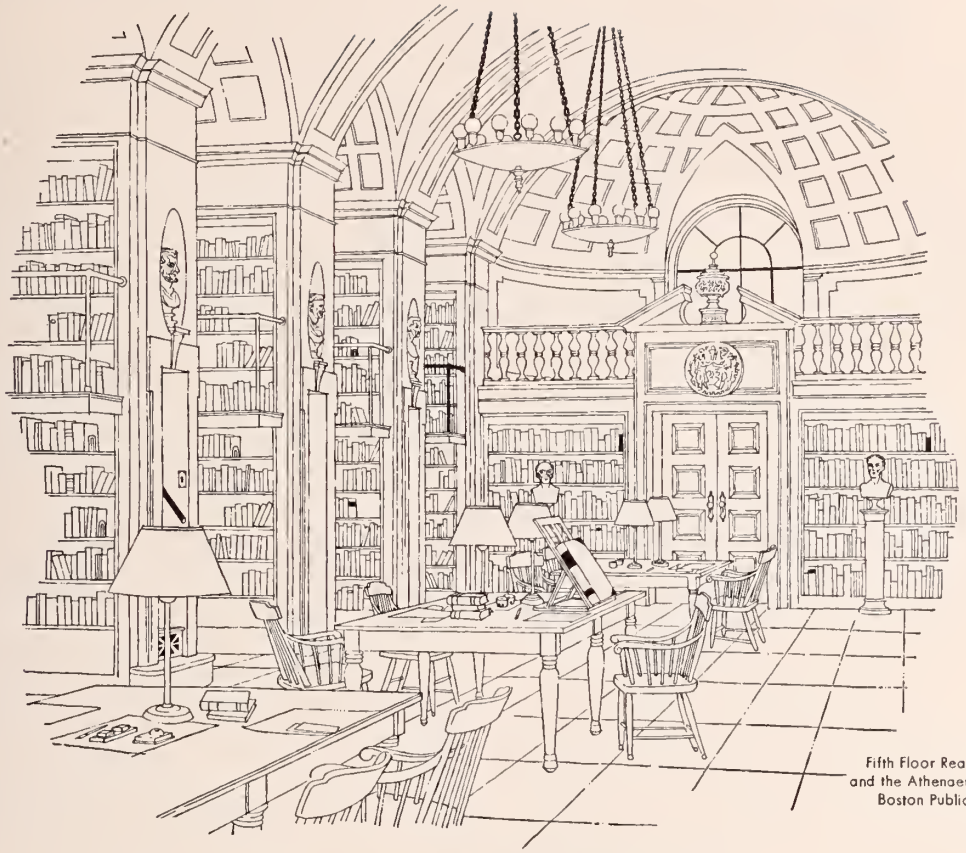
Doctors are busy people. So are reporters. Reporters have a deadline—a time just before their paper goes to press. They want the news while it is "hot." Doctors are always pressed for time to fill their regular schedules and take care of emergencies which are occurring constantly. Under such circumstances, it is not unusual that both doctors and newsmen seem impatient in the process of changing an accident into a news item.

Mr. Walter Pfister of the Sheboygan Press, who represented the press and radio on the panel, made a suggestion which might prove highly useful. He proposed that a simple form be prepared by the medical society and placed in the hands of responsible persons in the hospitals and physicians' offices. When the doctor treats an accident case, he can indicate on the form the facts that he feels he can divulge concerning the patient's condition. The form is left with the person in charge and, when the press or radio reporter calls, he can obtain the information he desires promptly and without annoying waste of time and "red tape."

Newsmen also suggested that the medical profession supply some sort of a clearing house at the national, state, and local levels to guide them in choosing what should be publicized concerning new and relatively untried drugs and treatments.

I wish to urge every doctor to attend one of these conferences. Whenever possible, extend a cordial personal invitation to your editor or radio station manager. Even better, bring him to the meeting personally. At least get acquainted with him and show him that physicians want to help him with his work. I am sure that he will reciprocate and be even more willing and helpful to physicians than he has in the past.

Albin F. Heidner M.D.



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Society Proceedings

Brown–Kewaunee–Door

The Brown–Kewaunee–Door County Medical Society held its April meeting at the Beaumont Hotel in Green Bay on April 10. The guest speaker for the evening was Dr. Kenneth D. Brown, professor of Biochemistry at Marquette University School of Medicine. His subject was "New Concepts of Water and Electrolyte Balance."

Douglas

The regular monthly meeting of the Douglas County Medical Society was held April 2 at the Hotel Superior, Superior. A scientific program was presented by the Giesen Clinic concerning urological problems in every day practice. Participants in the program were *Drs. Charles W. Giesen, Conrad W. Giesen, R. P. Fruehauf,* and *F. W. Reibold.* A dinner preceded the program and the business meeting followed.

Kenosha

At the April 3 meeting of the Kenosha County Medical Society which was held at the Elks Club in Kenosha, *Dr. H. A. Anderson,* medical director of the River Pines Sanatorium in Stevens Point, discussed the "More Recent Trends in the Treatment of Tuberculosis." Doctor Anderson concluded his talk with the presentation of x-rays to demonstrate a number of typical cases.

Sheboygan

Dr. Irvin L. Schroeder, Sheboygan, recently took part in a program broadcast over Station WHBL on progress in the cancer research program. A representative of the Sheboygan County Medical Society on the Sheboygan County Cancer Committee, Doctor Schroeder was interviewed on the development of new technics in cancer diagnosis and treatment. This program was one of a series of three which were presented by the American Cancer Society on research, services, and education.

Winnebago

Meeting at Holtz' in Winneconne on March 6, the members of the Winnebago County Medical Society heard an address by *Drs. H. L. Correll* and *Nathan Grossman,* members of the department of medicine of Marquette University School of Medicine. Their subject was "Cardiac Catheterization."

The April 3 meeting of the Society was held in Neenah at the Valley Inn. On this occasion *Dr. F. E. Mohs,* associate professor of chemosurgery at the University of Wisconsin Medical School, was the guest speaker. Doctor Mohs presented some diagnostic points and the treatment of external cancer.

American Academy of General Practice Fond du Lac Chapter

The Fond du Lac Chapter of the American Academy of General Practice met on April 10 in Waupun at the Hotel Waupun. The speaker for the evening was Dr. H. D. Bouman, professor of physical medicine at the University of Wisconsin Medical School, who chose "Rehabilitation of Non-neurological Injuries" as the subject of his address. This talk was the first in a series of lectures to be given before this group on the topic of rehabilitation.

Wisconsin Society of Pathologists

The Wisconsin Society of Pathologists, in conjunction with the American Cancer Society, held a Tumor Seminar on April 19 at Marquette University School of Medicine. The subject was "Tumors of the Organs of Special Senses" and was moderated by Colonel J. E. Ash, former director of the Armed Forces Institute of Pathology and who is at present located in Bethesda, Maryland. The scientific program, which was attended by physicians from all over the state, was followed by a dinner and business meeting at the Wisconsin Hotel.

Wisconsin Surgical Society

The annual clinical and scientific program of the Wisconsin Surgical Society was held in Madison on April 25 at the Methodist Hosiptal. Among those who participated in the program were *Drs. L. E. Holmgren, J. R. Steeper, G. H. Ewell, J. J. Mueller, R. T. Cooksey, J. C. Dean, K. E. Lemmer, J. W. Gale,* and *A. S. Jackson,* all of Madison; and *Drs. W. S. Bump,* Rhinelander; *W. G. Cameron,* Eau Claire; and *R. E. Galasinski,* and *D. W. Ovitt,* Milwaukee. Doctor Gale, who is president-elect of the society, addressed the evening meeting.

Wisconsin Surgical Club

The Wisconsin Surgical Club completed its annual spring tour on March 1 in Boston, Mass. The group left from Chicago on February 24, arriving in Toronto Monday morning. At the Toronto General Hospital Dr. R. M. Janes presented a program of papers and surgical clinics which was followed in the afternoon by a program at the Hospital for Sick Children arranged by Dr. R. M. Wansbrough. The next stop was in Montreal where the Club members were the guests of Dr. G. G. Miller, surgeon in chief of the Royal Victoria Hospital. Here, again, there was a schedule of surgical operations, ward rounds, and dry clinics. In the afternoon the Club was entertained at the Department of Experimental Surgery, McGill University, with discussions on the

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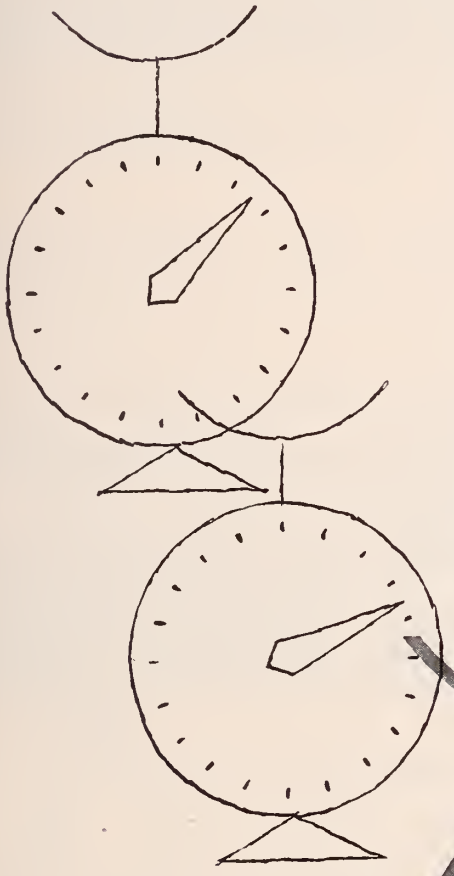

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1 Gardner, L. I., Butler, A. M., et al.: Pediatrics 5:228, 1950
2 Nesbit, H. T.: Texas State J. M. 38:551, 1943
3 Bull. National Research Council No. 119 Jan. 1950
4 Recommended Daily Dietary Allowances, Revised 1948, Food and Nutrition Board, National Research Council

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experimental work and progress by Dr. D. R. Webster and staff. On the second day in Montreal Dr. Jacques Bruneau and Dr. C. E. Hebert and members of the staff of the Hotel–Dieu and Notre–Dame Hospitals were hosts to the visitors.

Two days in Montreal were followed by an overnight trip to Boston where on Thursday the Club was the guest of Dr. E. D. Churchill and the staff of the Massachusetts General Hospital. During the day the visitors attended vascular rounds, surgical grand rounds, surgical operations, and a clinical pathological conference; in the afternoon a dry clinic was given by members of the staff. The second day in Boston was spent as guests of the surgical staff of the Lahey Clinic, Dr. R. B. Cattel and Dr. S. F. Marshall arranging the program of surgical clinics at the Baptist Hospital and Deaconess Hospital. The Club was entertained at luncheon by the surgical staff of the Lahey Clinic. The following day the visting surgeons were guests of Dr. A. J. A. Campbell and his staff at the Boston City Hospital.

Following the week of surgical clinics several members of the group were met by their wives in New York for a few days' visit in that city. Guests of the Club for the trip were *Drs. J. G. Garland* of Milwaukee and *J. W. McRoberts* of Sheboygan.

The members of the Wisconsin Surgical Club are as follows: *Drs. Peter Midelfart*, Eau Claire; *W. S. Bump*, Rhinelander; *C. W. Eberbach, C. F. Conroy, J. M. King*, and *F. A. Stratton*, all of Milwaukee; *S. E. Gavin*, Fond du Lac; *F. G. Connell*, Oshkosh; *E. R. Schmidt*, and *A. S. Jackson* of Madison; *S. B. Gundersen*, La Crosse; *R. M. Kurten*, Racine; *V. F. Marshall*, Appleton; and *T. J. Snodgrass*, Janesville. The late *Dr. Joseph Smith* of Wausau was also a member.

News Items and Personals

Medical–Surgical Day Held at Marshfield

Dr. C. Marshall Lee, Jr., assistant professor of surgery at the Cincinnati (Ohio) College of Medicine, was the guest speaker at the second annual Medical–Surgical Day held at St. Joseph's Hospital, Marshfield. His lecture on "Intestinal Obstruction in the Neonatal Period" closed a day-long series of clinics, conferences, and round table discussions.

The morning sessions consisted of two separate programs. *Drs. P. F. Doege* and *C. A. Vedder* conducted operative clinics in abdominal surgery; *Dr. C. L. Holmes*, thoracic surgery; *Dr. G. L. McCormick*, eye surgery; *Dr. N. J. Helland*, urologic surgery, *Dr. J. L. Burns*, anesthesiology; and *Dr. T. J. Rice*, gynecologic surgery. The other program consisted of medical rounds conducted by *Drs. R. S. Baldwin, F. A. Boeckman, G. S. Custer, K. H. Doege*, and *F. J. Gouze*. Pediatric rounds were in charge of *Drs. J. S. Vedder* and J. J. Suits, and *Drs. Stephan Epstein* and *R. J. Rowe* were in charge of the dermatology rounds. *Dr. J. B. Miale* and Doctor Lee, the guest speaker, directed the medical-surgical conference, which was followed by luncheon and round table discussions.

Dr. K. H. Doege served as moderator for the series of 15 minutes talks which were given in the afternoon. The speakers and their topics included Doctor Suits, "Hyaline Membrane Syndrome and Infant Death;" *Dr. J. M. Wickham*, "Diagnosis by X-Ray;" Doctor McCormick, "Prognosis for Vision After Cataract Extraction;" Doctor Custer, "Findings in 100 Consecutive Proctoscopies;" Doctor Mason, "Calcareous Tendinitis of the Shoulder;" Doctor Holmes, "Recent Developments in the Treatment of Achalasia;" Doctor Gouze, "Rheumatic Heart Disease Complicated by Pregnancy," and Doctor Helland, "Hematuria, an Invitation for Diagnosis."

Wausau Doctor Addresses Two Groups

On March 21 *Dr. H. W. Christensen*, Wausau, presented five case reports to the Twin City Urological Society at their meeting in St. Paul. Doctor Christensen also recently served as the guest speaker at a combined meeting of the Iron and Dickenson County Medical Societies at Iron Mountain, Michigan. On that occasion the subject of his address was "The Treatment of Malignant Tumors of the Genitourinary Tract."

Doctor Gehin Attends Two National Meetings

Dr. F. E. Gehin, who is associated with the Rice Clinic in Stevens Point, recently attended the meeting of the American Heart Association and the meeting of the American College of Physicians and Surgeons, both of which were held in Cleveland, Ohio. Mrs. Gehin and the couple's two children accompanied the doctor on the trip.

Fellowship Certificate Awarded

Dr. D. E. Dorchester of the Dorchester–Beck Clinic in Sturgeon Bay received a certificate of fellowship in the American Association of Industrial Physicians and Surgeons on April 23 in Cincinnati, Ohio. The doctor has also been re-elected to the board of governors of the Central State Society of Industrial Medicine and Surgery.

Heart Disease Topic of Address

Dr. C. D. Neidhold, Appleton, recently addressed a meeting of the Kimberly Homemakers Club in Kimberly. He pointed out that persons over 40 years of age should slow down and "act their age" and that overweight persons are more susceptible to heart disease and other complications.

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Physicians Address Nurses' Meeting

The Wisconsin State Nurses Association sponsored a private duty nurses' institute on April 24–25 in Green Bay. The main speakers for the meeting and their topics were *Drs. J. A. Killins,* "Use of New Drugs in Surgery;" *E. G. Nadeau, Jr.,* "Surgical and Nursing Care of Cataract Patients;" *G. B. Merline,* De Pere, "Treatment of Burns;" *V. F. Neu,* "Pre and Post Operative Care of Transurethral Surgery;" and *L. C. Miller,* "Indications of the Miller–Abbott and Levine Tube." Unless otherwise stated, all of the physicians are from Green Bay.

Doctor Shields Accepts Post

Dr. G. G. Shields of Abbotsford has been appointed health officer of District 5 of the State Board of Health. He will be stationed in Wisconsin Rapids and will direct public health work in Portage, Marathon, Clark, Wood, Jackson, Buffalo, Pepin, and Trempealeau Counties. He succeeds *Dr. A. L. Van Duser* who was recently appointed by the State Board of Health to the post of director of the divisions of venereal disease and cancer control.

THIRD AND TWELFTH DISTRICT NEWS

Doctor Kurtz Elected to Post

Dr. C. M. Kurtz, associate professor of medicine at the University of Wisconsin, was elected to the board of directors of the American Heart Association at its annual meeting at Cleveland, Ohio, April 17. The doctor is a past president of the Wisconsin Heart Association and a member of its board of directors, as well as serving as cardiologist for The Capital Times Kiddie Camp rest home for rheumatic fever patients.

Doctor Quinn Resigns from U. W.

Dr. R. W. Quinn, associate professor of medicine in the department of preventive medicine and student health at the University of Wisconsin, has resigned from that post effective July 1. Doctor Quinn will join the faculty of the Medical School at Vanderbilt University, Nashville, Tenn., where he will assume the chairmanship of the department of preventive medicine.

Doctor Middleton Honored by ACP

Dr. W. S. Middleton, dean of the University of Wisconsin Medical School, was given one of the highest honors of the American College of Physicians at the meeting of that group in Cleveland, Ohio, on April 23. Doctor Middleton was made a master of the organization and received a diploma which was presented by Dr. M. C. Pincoffs, Baltimore, Md., president of the College.

Dane

Meeting at the auditorium of the Veterans Administration Hospital, Madison, the members of the Dane County Medical Society heard an address by Dr. A. R. Calwell, professor of medicine at Northwestern University Medical School. Doctor Calwell's subject was "The Diagnosis and Treatment of Diabetic Acidosis."

Sauk

The Sauk County Medical Society met in Reedsburg on April 8 at the Sauk County Hospital and Home. The guest speaker for the evening was Mr. Clayton Harrop, director of the Sauk County Welfare Department, who discussed new relief roll method of the payment of medical fees. Another feature of the meeting was the showing of a film from the Cancer Society on "Malignancies of the Female Genitalia."

U. W. Societies Sponsor Lectures

Four University of Wisconsin Medical School societies recently sponsored lectures at the auditorium of Service Memorial Institute.

Alpha Omega Alpha, senior medical honorary society at the University of Wisconsin, sponsored a lecture on April 1. Dr. Harry Beckman, director and professor of pharmacology at Marquette University, chose "Not in the Thing Itself, or Pharmacologic Musings Regarding Neoplasia" as the subject of his talk.

On April 17 Dr. W. B. Tucker, sponsored by Alpha Pi of Phi Beta Pi, gave a lecture on "Chemotherapy and Current Status of the Treatment of Tuberculosis." Doctor Tucker is chief of the tuberculosis service of the Veterans Administration Hospital in Minneapolis, Minn.

"Irritability, Tension, and Anxiety" was the topic chosen by Dr. Roy R. Grinker at the April 29 lecture planned by Phi Delta Epsilon. The doctor is director of the Institute for Psychosomatic and Psychiatric Research and Training at the Michael Reese Hospital in Chicago.

A professor of physiology at the University of London and at present visiting professor of physiology at the University of Illinois, Dr. K. J. Franklin presented a lecture on May 6 under the sponsorship of Phi Chi. The title of the lecture was "The Foetal Circulation and Cardiovascular System, and the Changes They Undergo at Birth."

Milwaukee Physicians Honored

Four Milwaukee area physicians were recently elected fellows in the American College of Physicians at the annual meeting of the College in Cleveland, Ohio. They are *Drs. M. J. Ansfield, J. F. Kuzma, E. W. Mason,* and *H. W. Pohle.*

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Panel Held on Rheumatic Fever

Dr. S. F. Morgan, Milwaukee pediatrician, was one of the three speakers on a panel discussion of county services for rheumatic fever victims at a meeting of the Outagamie County Health Council and the Fox River Valley Heart Committee on April 30. He discussed the nature and extent of the disease. Doctor Morgan is chairman of the rheumatic fever committee of the Wisconsin Heart Association and chief of the cardiac clinic at Milwaukee Children's Hospital and Convalescent Home.

Officers Elected by Psychiatrists

Dr. Irwin Schulz was elected president of the Milwaukee Psychiatric Services at the February 12 meeting of that group, and *Dr. A. G. Martin* was elected to the board of directors. The guest speaker for the occasion was Dr. Charlotte Babcock, a psychiatrist from Chicago.

Milwaukee

The Child Welfare Committee of the Medical Society of Milwaukee County has taken an active interest in the promotion of the new school health program of the City of Milwaukee. The object of the plan is to place responsibility for the child's health on the parents and the family physician. The child is no longer to be examined by rote at specified intervals but rather is to receive health examinations, in the presence of the parent, at least three times during his school years by the physician most familiar with the child's problems.

Beginning in May 1952 the child or parent will receive a health form with instructions to take it to the family physician for completion. The physician, in turn, will conduct his examination and initiate any indicated therapy. All those not examined by their own physicians will be screened at school the following Fall. Audiometric and visual screening will be conducted by the schools.

The Child Welfare Committee is enthusiastic about this plan for five basic reasons: (1) It places the responsibility for the child's health on the parents and the family physician. (2) It is a more complete examination. (3) Immediate follow-up and treatment are greatly facilitated. (4) The family situation is known to the family physician. (5) It encourages a personal relationship between the doctor and the child.

Milwaukee Oto-Ophthalmic Society

The members of the Milwaukee Oto-Ophthalmic Society met on March 25 at the University Club. The guest speaker for the evening was Dr. Jerome Hilger of St. Paul, Minnesota. Doctor Hilger, who is on the faculty of the University of Minnesota Medical School, chose "Recurrent Head and Neck Pain" as the subject of his talk.

When the Society met on April 22 at the Wisconsin Club, Dr. C. N. Woolsey, professor of neurophysiology at the University of Wisconsin, was the featured speaker.

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G. E. Fox, Washington, D. C., to 320th General Hospital, APO No. 227, % Postmaster, New York, New York.

T. C. Puchner, Wauwatosa, to Dispensary MCAS, Cherry Point, North Carolina.

T. J. Dredge, Green Bay, to State Hospital, Yankton, South Dakota.

J. F. Walsh, Port Washington, to 6332 Medical Group, APO 239–1, % Postmaster, San Francisco, California.

H. E. Oppert, San Antonio, Texas, to Seventy-eighth Air Base Squadron, Madison Municipal Airport, Madison.

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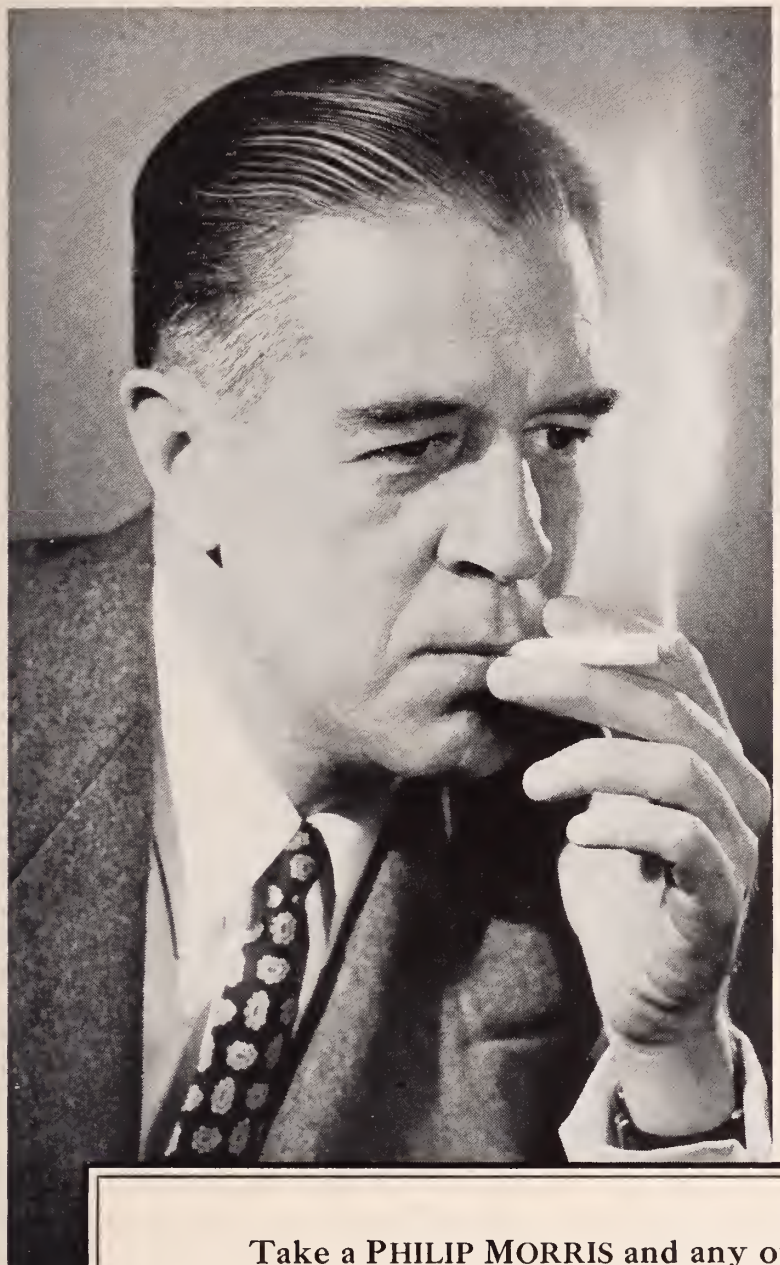
H. G. Pomainville, Nekoosa, to 480 East Grand Avenue, Wisconsin Rapids.

Eleanor V. Kuehn, Chicago, Illinois, to Mendota State Hospital, Madison.



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Vahlquist, B. and Hackzell, G.: Acta Paediatrica *38*: 622 (1949).

NO. OF CASES	SEX	AGE AT ONSET	CYCLIC VOMITING	DURATION OF ATTACK	INTENSITY
31	8 ♀ 23 ♂	3 yrs. (mean)	3 out of 31	2½ hrs.	severe in all cases

TABLE CONT'D

NO. OF CASES	UNILATERAL HEADACHE	NAUSEA	FLIMMER SCOTOMA	VERTIGO	HEREDITY
31	18 out of 31	31 out of 31	12 out of 31	6 out of 31	20 out of 31

(reference given above)

In a study of 400 adult migraine patients, it was revealed that 34% had suffered attacks before the age of 15.* These investigators concluded that childhood migraine was a much greater clinical problem than was previously believed and that psychodynamic mechanisms played an important part in the disease.

These criteria are useful in diagnosis:

Headache attacks with symptom-free intervals plus (at least two of the following) nausea, scintillating scotoma, hemicrania, and hereditary predisposition.

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In the adolescent age group, 12 to 18 years of age, the dosage may gradually be increased as necessary up to the usual adult dose, i.e., two tablets when the attack appears imminent followed by one tablet doses at half hour intervals until the attack is aborted. *(Total maximum dose for adults: six tablets for each attack.)*

*Katz, J., Friedman, A.P., and Gisolfi, A.: New York State J. Med. *50*: 2269 (Oct.) 1950.

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DEATHS

Dr. George H. Scheer, 74, retired Sheboygan physician, died on April 7 in a Sheboygan hospital following a short illness.

A native of Sheboygan, the doctor graduated from the University of Wisconsin and received his medical degree from Rush Medical College, Chicago, in 1903. He began his practice in Sheboygan in 1904 and was active until about fifteen years ago when he limited his practice to friends and old patients.

Doctor Scheer was nationally known through his hobby of breeding and growing distinctive varieties of gladioli. The "white gold" gladiolus he developed in 1940 won the American Home Achievement medal, the silver medal of the Canadian Gladiolus Society, and the gold medal at the Washington State fair in 1941, in addition to seventeen other blue ribbon awards.

The doctor was a life member of the Wisconsin Gladiolus Society and the Sheboygan chapter of that society, a member of Alpha Omega Alpha, honorary medical fraternity, and Phi Beta Pi, a Rush College medical society.

Survivors include his wife, two sons, and a daughter.

Dr. Xenna P. Bent, Benton physician for 37 years, died suddenly on March 31 at her home. She was born in 1890 in Virginia.

Doctor Bent received her early education in Virginia and her medical training at the University of Cincinnati. She moved to Benton from West Union, West Virginia.

Survivors include a son and a daughter.

Dr. Robert L. Eagan, La Crosse physician, died suddenly on April 4 in a La Crosse hospital. He was 61 years old.

Born January 21, 1891 in Muscoda, the doctor graduated from Marquette University School of Medicine in 1915. He established his first practice in Lone Rock and then joined the army medical corps during World War I. Upon his release from military duty, he took postgraduate work at the Cook County Hospital, Chicago, in the specialty of eye, ear, nose and throat. In 1920 he joined the staff of the Grandview Hospital in La Crosse, and in 1935 opened his own office in that city to practice in his specialty.

Doctor Eagan was a member of the American Board of Otolaryngology, the La Crosse County Medical Society, the State Medical Society, and the American Medical Association.

Survivors include his wife, a son, and two daughters.

Dr. Gerald T. Savage, 72, retired Milwaukee physician, died February 14 at his home.

Born in Cedarburg on May 26, 1879, the doctor was a 1911 graduate of the Marquette Medical College, and later served as a first lieutenant in the

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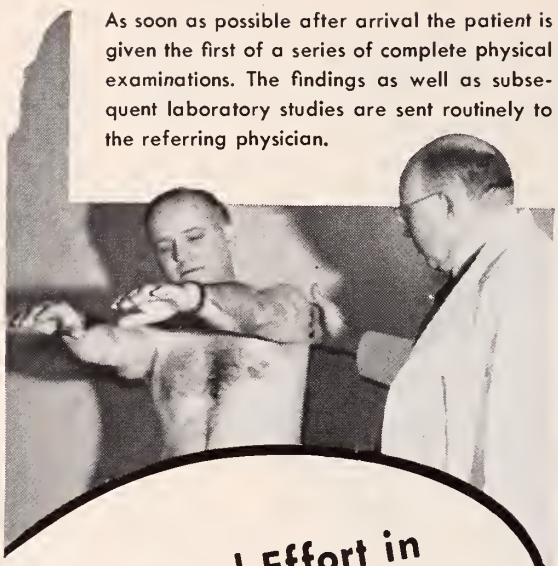

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[*This is the second of a series describing the successive steps in the treatment of the "Problem Drinker."*]

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army medical corps during World War I. He was industrial surgeon for the Falk Corporation for more than 25 years.

Doctor Savage was a member of the Medical Society of Milwaukee County, the State Medical Society, and the American Medical Association.

Dr. Sylvester R. Ridley, 67, Mineral Point physician, died on March 20 at his home following a short illness. He was born in Golt, Ontario, Canada on July 20, 1884.

A 1913 graduate of the Hahnemann Medical College and Hospital of Chicago, the doctor served his internship at the Dee Memorial Hospital, Ogden, Utah. He established his practice in Mineral Point in 1914 and had been an active practitioner in that city until his death. He was on the staff of the Iowa County Home and St. Joseph's Hospital, Dodgeville, where he had also served as chief of staff. He was a member and past president of the Hahnemann medical group in Wisconsin.

Active in civic affairs the doctor had been city health officer for Mineral Point for the last several years and was a past president and member of the Board of Education.

He was a member of the Iowa County Medical Society and the State Medical Society.

Survivors include his wife and a daughter.

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references:

1. Journal-Lancet 70:298, 1950.
2. Rocky Mountain M. J. 48:99, 1951.
3. Am. J. M. Sc. 218:298, 1949.
4. J. M. Soc. New Jersey 48:12, 51.
5. Am. J. M. Sc. 219:139, 1950.
6. U. S. Armed Forces M. J. 1:332, 1950.
7. Circulation 1:502, 1950.
8. Cincinnati M. J. 31:137, 1950.
9. Southern M. J. 44:44, 1951.
10. M. Times 79:83, 1951.
11. J. A. M. A. 146:250, 1951.
12. Circulation 1:508, 1950.

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CORRESPONDENCE

March 27, 1952

A. G. Koehler, M. D., Secretary
Wisconsin State Board of Medical Examiners
46 Washington Boulevard
Oshkosh, Wisconsin

Dear Doctor Koehler:

A question is frequently put to me, and I am always puzzled as to how best to answer it. When Doctor Dawson was secretary of the State Board of Medical Examiners, I think he and I were in pretty fair agreement relative to it, and it has just occurred to me that I should tell you of the question and how I answer it so that if my views are not in accord with yours, we will have opportunity to reach some common agreement upon the point.

I have reference to the situation, not infrequently presented, where a physician comes to Wisconsin and associates in practice with others here in the state. His arrival is in the interim between examinations conducted by the State Board of Medical Examiners, and the question presented is what, if anything, he may do in the field of medical practice.

I advise very strongly against engaging in any activity which, in itself, constitutes medical practice. I advise these physicians that as unlicensed physicians in the state, their malpractice insurance may be void. They cannot sign vital statistics, they cannot appear in court, and they are not entitled to use any legal method for the collection of fees.

I suggest that all case records must be entered by the licensed physician or physicians in the office, that the unlicensed physician should not see patients and precribe for them independently of consultation with those who are licensed. I advise that all prescriptions issued must be issued by licensed physicians and that the non-licensed physician should in all ways avoid any implication that he is actively engaged, on his own, and as a licensed physician, in the practice of medicine.

Frankly, I am afraid that I discourage this situation whenever possible as I feel that there are many legal implications involved and a physician, particularly one who has been engaged in practice over any period of time, may unwittingly, probably as a matter of habit, engage in activities which may subject him to criticism or actual difficulty.

Are you in general agreement with the reactions I express? I will be glad to hear from you.

Sincerely yours,

/s/ C. H. Crownhart
Secretary

April 1, 1952

Dear Mr. Crownhart:

Thank you for your letter of March 27, concerning my opinion relative to the practice of medicine by unlicensed physicians in Wisconsin between the time they arrive in the State of Wisconsin and the time they are examined by this Board for purpose of licensing them.

This continues to be a situation which presents itself repeatedly and which is still very much a problem of enforcement of both Wisconsin Statutes and Board policy.

While a physician may enter the State of Wisconsin as a locum tenems, an "apprentice," or a resident, with every intention of becoming licensed at the first Board meeting in the future, he is, although unintentionally in some cases, still practicing medicine illegally. It is almost impossible for a physician to be employed in one of these capacities without engaging in some activities which constitute the practice of medicine.

We are heartily in accord with your opinion on this subject, and the policy expressed by Doctor Dawson on behalf of the Board at that time is still in effect.

Yours very truly,
Wisconsin State Board of Medical Examiners
/s/ A. G. Koehler, M. D.
Secretary

Macon County Medical Society
Decatur, Illinois

February 28, 1952

Dear Sir:

Of all the journals which come to our office, I find the Wisconsin Medical Journal serves me more adequately than all the rest. Your timely discussion having to do with Federal Legislation is very apropos. I fear I would miss your journal tremendously especially since I have been kicked downstairs having served as president of the State Medical Society and now I am President of the County Medical Society.

I still remember with pleasure my visit to your State Society Meeting in Milwaukee and the fine hospitality accorded me at your meeting. I was sorry you were not present at the meeting of the National Conference on Medical Service, Sunday, February 10, in fact I saw very few of the Wisconsin men there. The meeting was not too well attended, but the Honorable Everett McKinley Dirkeen, United States Senator from Illinois, gave one of the best discussions on "Our Citizens and Their Doctors." The address of President R. E. Fitzgerald of Milwaukee was a masterpiece and was very

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well received by the conference. I hope that the journal will carry his address in full as all members of the medical profession should avail themselves of the opportunity to read same.

With kindest personal regards, I remain

Very truly yours,
/s/ I. H. NEECE, M. D.

Editor's Note: Marked copies of the Forum section of the *Wisconsin Medical Journal* are sent those whose activities or remarks are the subject of an article. About 15 or more such copies are sent each month. Acknowledgements are interesting and will occasionally be quoted in this column:

Dane County Association of Health Councils
March 11, 1952

Dear Sir:

After years of earnest endeavor on the part of the Dane County Association of Health Councils, it is indeed most gratifying to receive recognition from a society such as yours.

We are all very favorably impressed with the articles in the January Journal.

Sincerely,
/s/ MRS. E. R. CRANDALL
Secretary

Treasury Department
Bureau of Narcotics
March 12, 1952

Dear Sir:

Thank you for calling my attention to your good article "Commissioner Explains Harrison Law" in the February issue of The Wisconsin Medical Journal.

I think it is very helpful to publish articles like this, and shall be glad to communicate with you when I have any suggestions for future issues.

Thanking you for your cooperation, I am

Sincerely yours,
/s/ H. J. ANSLINGER
U. S. Commissioner of Narcotics

The University of Chicago
Department of Obstetrics and Gynecology
March 19, 1952

Dear Sir:

I appreciate very much your thoughtful letter of March 14. I enjoyed the whole day affair in Milwaukee last Thursday. It was interesting and I enjoyed the industrial aspect in the afternoon. The evening program I thought was good and appropriate. I thoroughly enjoyed the Round Table; I hope that I had something of value to offer the audience, and that they understood the points that I hoped to make.

I was particularly impressed with the outstanding turnout for this affair, which I think speaks well of all those who were responsible for supporting the program. It has always been a pleasant and delightful experience to come up to Milwaukee or into Wisconsin to meet with the doctors.

I want to congratulate you and the rest of your staff for the way you handle these programs; it is indeed well done.

Sincerely,
/s/ H. CLOSE HESSELTINE, M. D.

U. S. Department of Labor
Bureau of Labor Standards
March 26, 1952

Dear Sir:

Thank you very much for the minutes of the conference on medical problems relating to migrant workers which you were kind enough to send me. We found these very interesting and we are especially gratified to learn that the State Medical Society was interesting itself in the plight of the migratory agricultural workers. There may be other States in which the Medical Association has taken the lead in this field but Wisconsin is the first one with which I have come in contact.

If you have any future meetings and any other further ideas to promote we would be very glad to have a report of those meetings also.

Sincerely yours,
/s/ MARY SKINNER

Fall Creek, Wisconsin
February 8, 1952

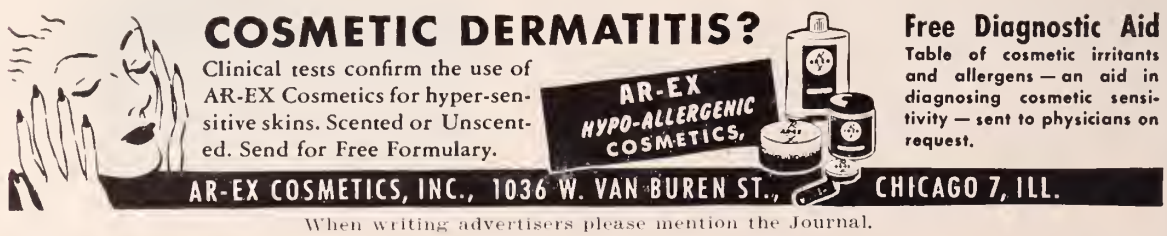
State Medical Society of Wisconsin

The members of the Twin Pines 4–H Club and myself wish to thank the society for awarding our club the State Health Achievement certificate.

We feel honored and proud to receive it. We are sure it will be an inspiration for us to carry on.

Thank you most sincerely.

/s/ MRS. HENRY TUMM



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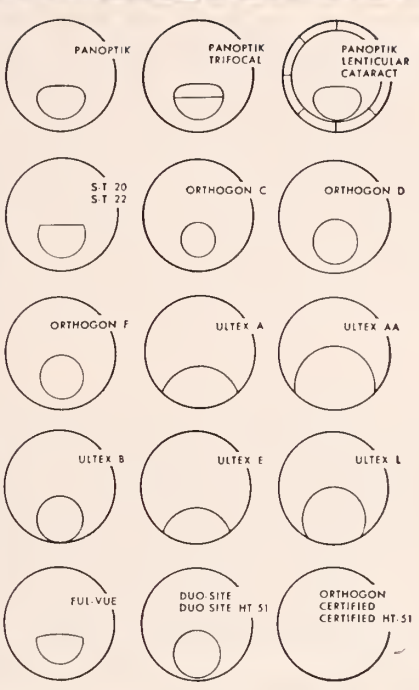

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Address as follows: Medical Library Service, Service Memorial Institute Building, North Charter Street, Madison, Wisconsin.

The Medical Clinics of North America. Chicago Number. Symposium on clinical advances in medicine. Philadelphia and London, W. B. Saunders Company, 1951.

This volume consists of 20 authoritative contributions dealing with the clinical aspects of a group of subjects important in the practice of clinical medicine. In addition to comprehensive, yet brief, discussions of essential hypertension, poliomyelitis, regional enteritis, ulcerative colitis, the male climacteric, and the problems relating to the aged patient, unusually thorough considerations of the treatment of Laennec's cirrhosis, the lymphomas, multiple myeloma, syphilis, tuberculosis, abnormal bleeding of various types, and the use of steroids in rheumatoid arthritis are included. The articles are well organized, clearly and concisely written. Especially impressive is the conservative manner in which controversial material and new and unproved methods are handled.

This excellent symposium is recommended to both internists and general practitioners.—M.J.M.

The Management of Fractures, Dislocations, and Sprains. By John Albert Key, B.S., M.D., Clinical Professor of Orthopedic Surgery, Washington University School of Medicine; Associate Surgeon, Barnes, Children's, and Jewish Hospitals, St. Louis: and H. Earle Conwell, M.D., F.A.C.S., associate professor of Orthopaedic Surgery, University of Alabama School of Medicine; chief of the Orthopaedic Service, South Highland Infirmary; consulting Orthopaedic Surgeon to Carraway Methodist Hospital and Baptist Hospital; attending Orthopaedic Surgeon, Children's Hospital, Jefferson–Hillman Hospital, East End Memorial, and St. Vincent's Hospital, Birmingham, Alabama. Fifth edition. St. Louis, The C. V. Mosby Company, 1951. Price $16.00.

This is the fifth edition of this book by Key and Conwell. The mere fact that it is the fifth edition is a testimonial to its popularity. The methods described are practical. The book is complete and authoritative. It should be in the possession of every doctor who holds himself out to the profession as a fracture man. It should be his váde mécum.—R.E.B.

Genetics in Ophthalmology. By Arnold Sorsby, research professor in ophthalmology, Royal College of Surgeons and Royal Eye Hospital; surgeon, Royal Eye Hospital, London. St. Louis, The C. V. Mosby Company, 1951. Price $9.50.

This book, like others by this gifted author, presents a relatively short survey of present knowledge concerning the ophthalmologic aspects of medical genetics.

Comments in the preface bring into sharp relief the changing aspects of eye diseases which have led to blindness over the past century and a half. In this the author shows that many extraneous factors, particularly infections, now play a relatively insignificant role, so that present statistics on the blind and partially blind reveal the ever-increasing importance of congenital, hereditary, and developmental factors.

The author's approach to this relatively neglected subject is refreshing in that he shows us that "medical genetics is not concerned solely with the collecting of curious pedigrees of the unconsidered trifles of pathology but is to be regarded as an attempt to elucidate some aspects of the constitutional basis of disease." He feels that the fatalism with which ophthalmologists generally regard genetic affections is unfounded and he offers a hopeful note for their eventual control. In addition to the discussion of the more commonly recognized hereditary

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anomalies of the eye, the author suggests that many eye diseases which appear in middle age and later life, such as senile cataract, primary glaucoma, senile macular degeneration, corneal and macular dystrophies, and others, may be genetically determined abiotrophies. Some may challenge this because of inadequate substantiating data.

The book is divided into three sections: I.—Theoretical; II.—Isolated Ocular Anomalies; and III.—Generalized Disorders with Ocular Aspects.

The first section deals with modes of inheritance, clinical varieties of genetic disease, and prospects of control of genetic disease. Especially interesting are the comments on the influence of external environmental factors which may release a genetic potentiality or at times suppress a genetic trait. Numerous human pedigrees are given, illustrating various types of dominant, recessive, recessive sex-linked, and many other types of inheritance.

Section II will be of greatest interest to the practicing ophthalmologist. The more common, as well as rare, anomalies which affect various structures of the eye are described, with beautiful illustrations and many pedigrees. Included are chapters on glaucoma, refraction and its aberrations, anomalies of ocular movements, corneal dystrophies, cataract, uveal, and retinal diseases. The discussion of corneal and macular dystrophies will prove immensely helpful in the interpretation of many obscure lesions, the etiology of which we frequently search for in vain.

The final Section (III) presents a brief discussion of some of the better known syndromes which are grouped as predominantly mesodermal, ectodermal, and neuro-ectodermal.

The book is a worthy successor to Doctor Sorsby's other valuable contributions to modern trends in ophthalmology. It covers 242 pages and is followed by an excellent bibliography. The paper, type, and illustrations deserve especial praise. The cost of the book is relatively high, no doubt due to the large number of illustrations, many of which are in color.

While the subject may appear complex to the average reader, much of practical value will be found in the discussion and description of diseases which are encountered in everyday practice.—F.A.D.

A Review of Medicine. By Members of the Faculty Northwestern University Medical School. Edited by Benjamin Boshes, M.D., M.S., Ph.D., Associate Professor of Nervous and Mental Diseases, Northwestern University Medical School; Attending Neuropsychiatrist, Passavant Memorial and St. Luke's Hospitals, Chicago, Illinois, and senior consultant in neurology, Veterans Administration Hospital, Hines, Illinois. Sixth edition. Chicago, Chief Printing Company, 1951. Price $15.00.

For individuals wishing to rapidly review the subject matter of the clinical years of Medical School, this volume presents an aid specifically designed for the purpose. It should be extremely useful to those preparing for state or national board examinations. The basic sciences are not covered, but there

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are chapters on medicine, surgery, obstetrics, gynecology, genitourinary surgery, orthopedic surgery, fractures, pediatrics, otolaryngology, ophthalmology, neurology, dermatology, and psychsomatic medicine. The classical systematic approach is employed and the material is presented in outline style with very brief elaboration where needed on the outline headings. While exception might be taken to some of the opinions expressed, a dogmatic approach is unavoidable in an outline of this sort. Each subject is discussed by a different individual and these writers are for the most part well recognized experts in the field so that the material is for the most part quite authoritative. This book can be highly recommended for the use for which it was intended. The approach is so superficial that it would be valueless for any other purpose.—J.L.S.

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The book conforms well to its title. Its topics are well presented and should be clear even to a novice in the field of medical statistics. At the same time, the book is a handy manual to rather more mature workers. I do not feel that the statement on page 19 that certain computational methods ". . . tend to be restricted to those fortunate enough to command the services of professional statisticians armed with appropriate calculating machines." is fair. It would seem to me always desirable to show the shortcuts to everyone, whether he will use machines or not. For example, the formula given for correlation (equation 26, pg. 32) is not the best working formula for many purposes.

The general level at which the text is aimed seems to have a high variability. For example, there is a decided contrast between the discussion in paragraph 4, pg. 14, and the directions for solving a 2x2 system of equations on pg. 16.

The discussion of significance and probability, pp. 53–57, is excellent.—F.G.

The Medical Clinics of North America. New York Number. Symposium on Obstetrics and Gynecology. Philadelphia and London, W. B. Saunders Company, 1951.

With one exception, this volume is a symposium on obstetrics and gynecology, consisting of a number of common complications in this field and, in general, represents a consensus of modern thought on these subjects.

The chapters on medical complications of pregnancy, such as syphilis, tuberculosis, heart disease, toxemias, and urologic abnormalities, are especially well done and are of real value.

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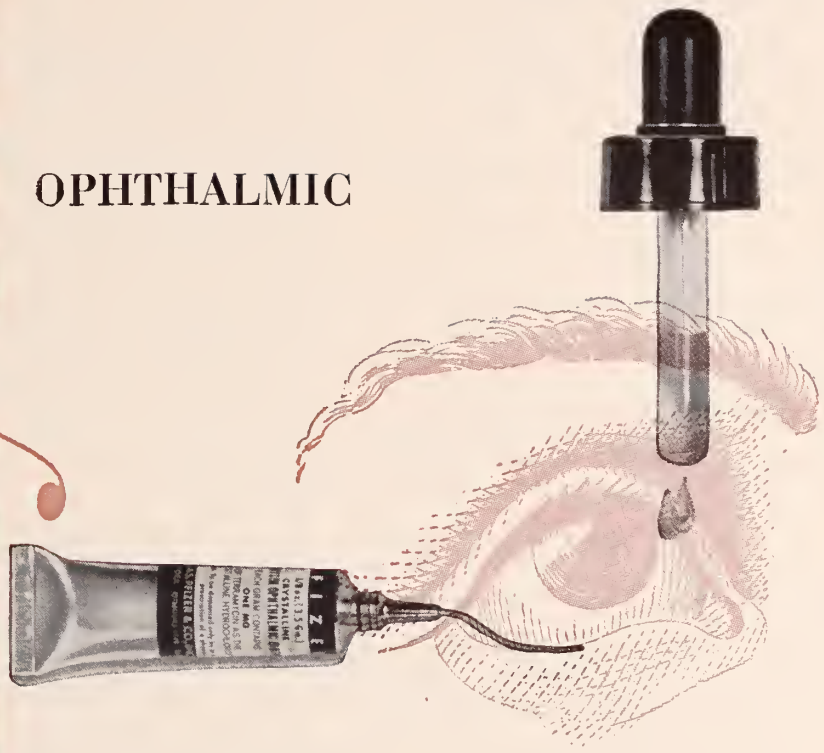

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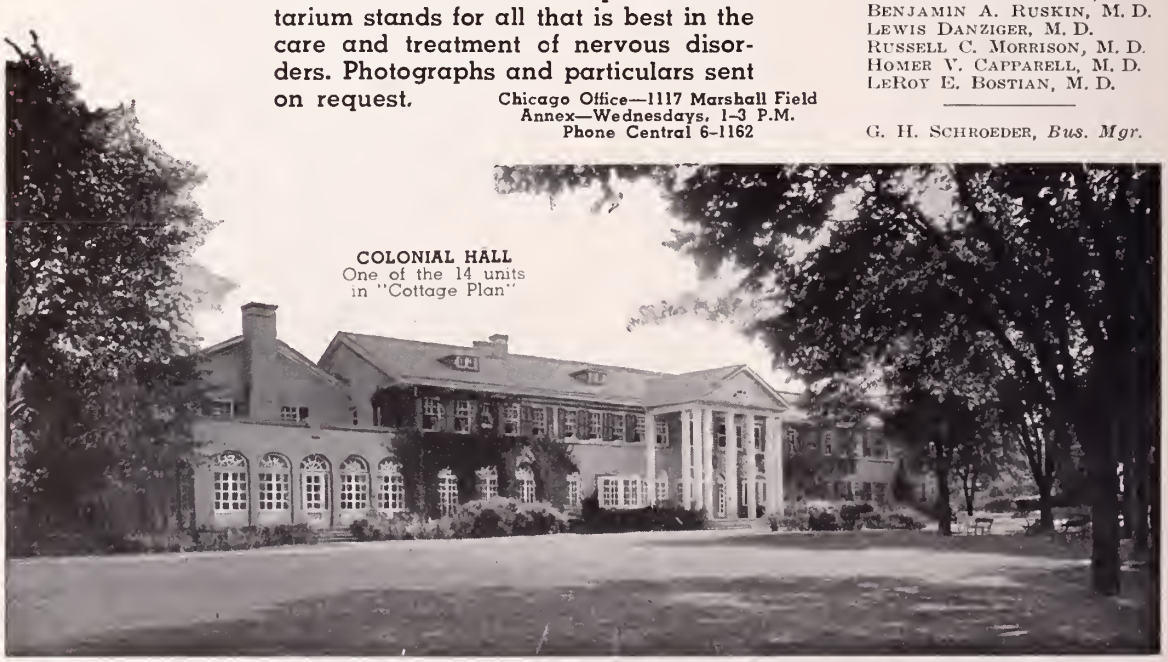

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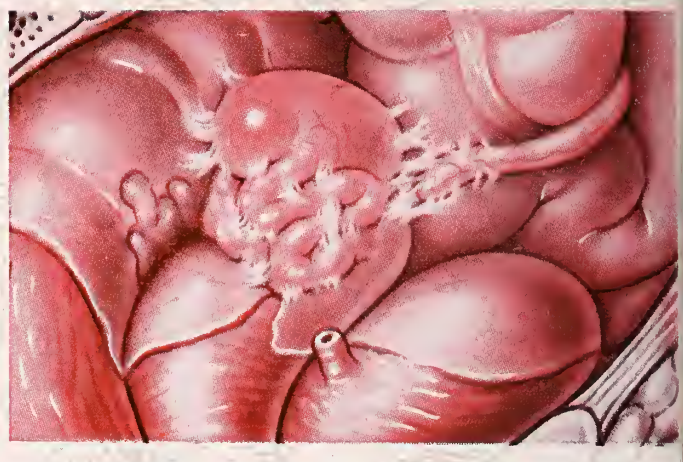

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1. Greene, G. G.: Kentucky M. J. *50*:8, 1952.
2. Stevenson, C. S., et al.: Am. J. Obst. & Gynec. *61*:498, 1951.

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1. Mitsui, Y., et al.: Antibiotics & Chemotherapy 1:253 (July) 1951.
2. Mitsui, Y., and Tanaka, C.: Antibiotics & Chemotherapy 1:146 (May) 1951.

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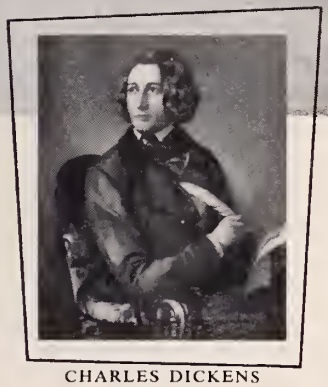

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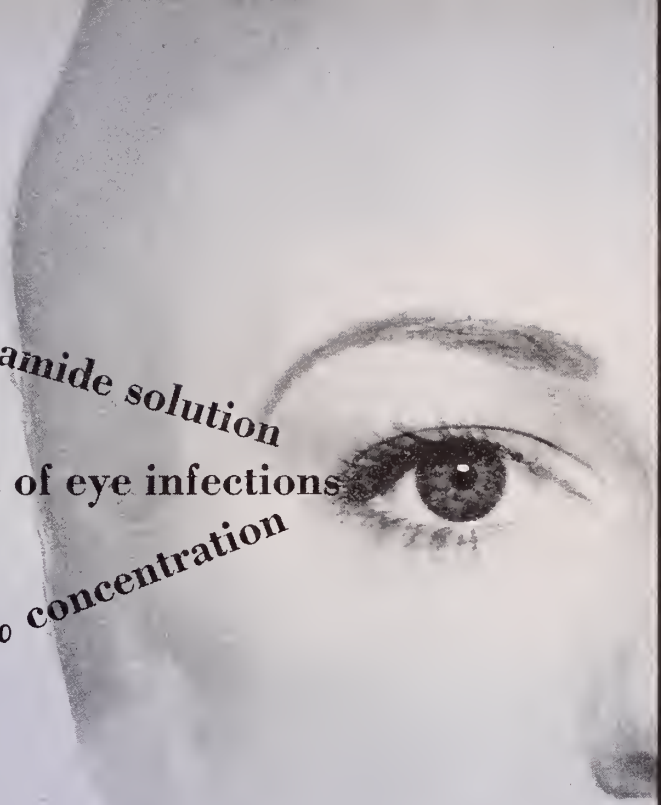

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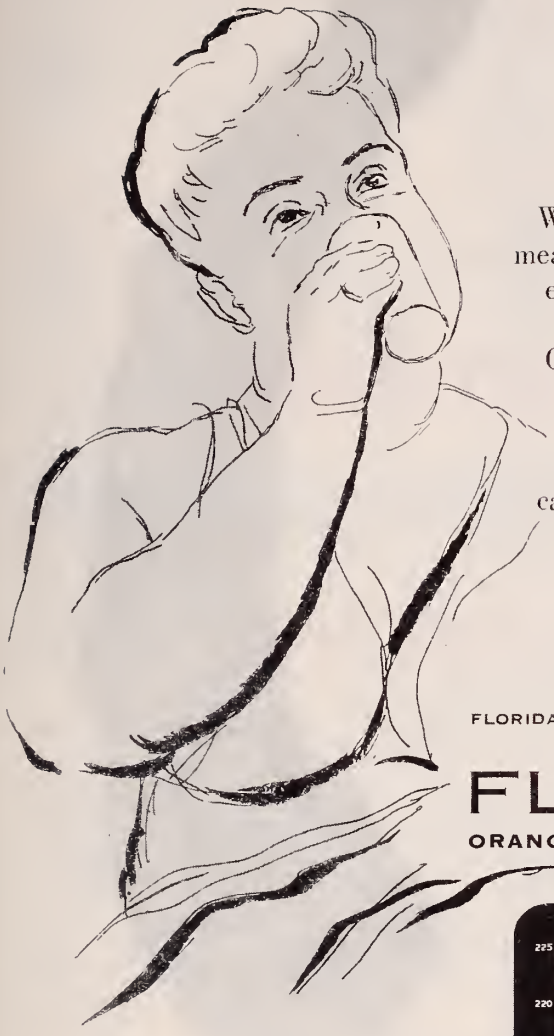

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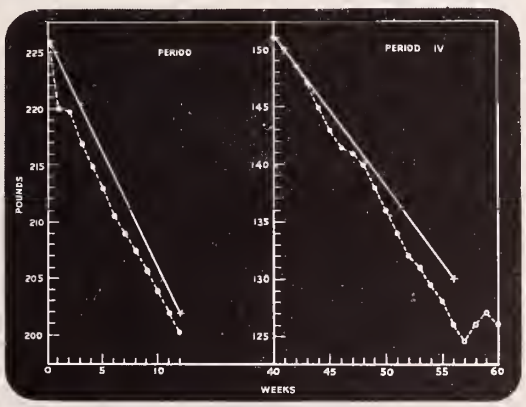

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« « « EDITORIALS » » »

Civil Defense—Whose Job?*

Since this issue of the *Wisconsin Medical Journal* is primarily concerned with civil defense as preparation against atomic disaster, the question will arise —"What is civil defense?". Civil defense, boiled down to its essence, means: the organization of the civilian population to minimize—and survive—the effects of enemy action.

It is needless to repeat that the threat of another and far more devastating world war is at this time upon us; that such a war promises to be of a type that would bring widespread ruin to our large cities and decimate their populations; or that this nation must get on at once with the job of preparing itself to receive and survive the holocaust that, for the first time in its history, threatens its non-military institutions and people.

A sound civil defense program calls for public interest, proper planning, and energetic action far and above that which has so far developed. We have no intentions whatever of belittling the many substantial accomplishments, but let's face the facts. The movement has not caught on. America is not yet aroused. Mr. and Mrs. John Q. Public at this very moment have no clear concept of just what they might be in for tomorrow—next month—next year. Above all, they have no realization of the simple fact that pitiable suffering and death in their own home may very well hinge upon their understanding of what training and regimentation means in the face of quick disaster. Today and tomorrow let us draw a blueprint of how we of the health professions, working arm in arm with established authority, are to lead, yes even force, our beloved country to get along with this job.

As doctors, we fully understand that heavy enemy attack on our cities would create many and diverse problems of rescue and repair. The medical problem of caring for the injured and dying would be but one among many—the mass movement of people and their welfare, policing, fire control, food and water supply, sanitation, communications, transport, debris clearance, primary rescue, stockpiling and supply, identification and burial of the dead, decontamination and many, many others. But let an air burst fall over downtown Milwaukee and the single thing in the minds of hundreds of thousands lying maimed and burned in the streets would be, "Where is a doctor?".

*Excerpts from the keynote address by Dr. James C. Sargent, Chairman of the Council on National Emergency Medical Service of the American Medical Association, presented November 9, 1951.

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This simple fact places a large responsibility on the medical profession. We ourselves have an enormous job ahead in organizing our health services against the possibility of civilian disaster of fantastic proportions. Ours is a need for genuine oneness of purpose and action between all of those of us working in the health field. Until that sort of a united effort has been achieved, we will not have gone far beyond the stage of mimeographed outlines of organization and procedure.

The interest of people everywhere must be captured and their actual training and participation in the program gained. For civil defense to be ready to work, people everywhere must be trained in the rudiments of self protection and first aid, and many thousands must be recruited and trained as block wardens, auxiliary police, rescue teams, litter bearers, fire fighters, radiation monitors, and on and on through countless other special training programs. We must train ourselves in the peculiar problems that will be incident to disaster of this type. We must organize ourselves so that each physician has a definite job to do, knows how to do it, and holds himself in readiness for destiny.

Perhaps, in typical American fashion, we are going to have to wait until disaster has struck. Perhaps the organized civil defense movement will ultimately come to embrace a direct effort at gaining necessary legislative support and an out-and-out sales campaign to enlist wide public participation in its training program.

In the meantime, however, there is much that might be done if your organizations, and mine, were to take full advantage of their peculiarly close relationship to the public in this matter of widespread disaster and, through a concerted effort, help materially in arousing public notice of the sword that hangs so perilously over us all.

The sands of time are fast running out.

The Role of the Captain in Organizing a Medical Team

The captain of a mobile medical team must first of all be convinced in his own mind that there is a true need for preparedness against the catastrophic possibility of an atomic bomb attack.

Secondly, he must appreciate the inherent inertia existing in most of the citizenry (including doctors) of the Midwest; and he must work patiently and persistently to overcome it.

His success or failure will depend largely upon finding the right type of cooperative team members. The deputy team captain and the business manager should first be chosen and should be helpful in choosing the other team members; they should be willing to work under circumstances that are far from encouraging—men who will be willing to go ahead and perfect an organization without waiting for the government to provide the theoretically necessary articles of equipment.

The organizational plan should take the form of a pyramid, wherein responsibility is relegated but not divided. In this way, each of the key men have close contact with the captain, as well as close control over his unit. Likewise, the captain of the mobile medical team must see that his own pyramid is closely integrated into the larger pyramid of civilian defense.

Each department should be closely organized and its members preferably associated in their usual civilian routines. Thus, an entire group of stretcher-bearers might well be selected from people working in the same building. This arrangement simplifies the telephone communication system.

First aid instruction is of paramount importance. Success depends on an instructor who has the ability to make the series of lectures pleasant and profitable for the class.

Radar monitors should have some natural interest in the type of work that they are to do, either by training, experience, or as a hobby. Radar monitors with a desire to learn and make use of the information available will present no problem to the team captain.

It is also the captain's responsibility to see that an adequate system of communication is established, whereby word can be quickly passed to each member of the team when an emergency arises. The business manager and clerks, if working at the same place of business, can be the nucleus of a chain system of telephone calls that will save time and confusion.

Finally, when the team is organized, and every man has his duties and responsibilities well outlined, it still remains for the captain to keep the members informed of new developments and plans. Regular routine meetings are not usually indicated, but a few meetings should be held, as necessary, and members brought up-to-date. Unnecessary meetings with a lack of purpose will tend to dispel interest in the organization.

We have high hopes that the needs for our services will never arise. But if it does, we may well find that the margin of survival will be proportionate to our preparedness along the lines of civil defense.—Nathan E. Bear, M. D., Monroe.

A Committee Writes the Journal

This special edition was prepared by the Committee on Civil Defense of the State Medical Society of Wisconsin, M. J. Musser, M. D., Madison, chairman. These pages describe a casualty care plan that may mean the difference between life and death for thousands of Wisconsin citizens, if and when a disaster occurs. The efforts of this committee deserve no less than the gratitude and support of the medical profession and the people of Wisconsin.

Comments from the Wisconsin Press

"Too Many Asleep to Danger"

"Wisconsin is progressing slowly in civil defense. Public apathy is one of the major causes. Almost everyone must take some small part in civil defense if we are to have an effective program.

"The state office of civil defense has just called attention to the findings of a survey of public attitudes toward civil defense. This showed that most citizens realize the need for civil defense but few know what should be done for the protection of themselves, their families and their communities in case of a great disaster. Still fewer have answered repeated calls for volunteers. Many have not even heard that volunteers are urgently needed.

"The survey was confined to people in large cities. Indifference is even more widespread in areas where people don't expect ever to be the target of an atomic bomb. Such people don't seem to realize that they can be the victims of enemy sabotage of utilities or victims of biological or chemical attacks on humans and livestock and crops. They don't seem to realize that they should be prepared to help feed, clothe and shelter thousands of injured and uninjured who would flee any city hit by an atomic bomb.

"Little communities as well as big communities, rural people as well as urban people, will have to do their share if Wisconsin is going to be really well organized for civil defense.

"Any Wisconsin organization can help by direct appeals to its own members. County and local officials should, as a matter of duty, see that the needs of civil defense are brought home to constituents. Anyone can help in civil defense recruiting.

"The man or woman who doesn't make the contribution he can to civil defense is not doing his part in a period of great danger."—MILWAUKEE JOURNAL, May 10, 1952.

* * *

"Setback for Government"

"Years ago, the Oregon State Medical Society set up a prepaid hospitalization program, which Oregon people could join at a modest monthly cost if they wished to. In 1949, the government brought an anti-trust suit against the plan's sponsors, in which the main claim was that participating doctors conspired to eliminate prepaid medical care plans not sponsored by themselves.

"After a five-months trial, resulting in an 8,000 page court record, a Federal judge threw out the suit in toto. He held that the Oregon doctors had established their plans to 'save their profession from socialism,' and that no court should require organized medicine to 'remain a sitting duck while socialism overwhelms it.'

"This didn't satisfy the government, however. At a heavy cost to both the taxpayers and the defendants, the case was taken to higher courts. It finally ended last April, when the United States Supreme Court, with but a single dissent, upheld the trial court and tossed out the monopoly charges.

"Of this, the president of the Oregon State Medical Society said, 'In my opinion this decision is a sharp setback for the administration forces in their campaign to regiment the American people and the American medical profession under a Federal compulsory health insurance system.' And the Portland Oregonian said editorially, 'The United States Supreme Court upheld an enlightened effort on the part of medical men to meet a social need . . . The decision is a victory for a profession that has tried successfully to solve a pressing problem by its own initiative.'

"So socialized medicine has taken one more setback—and the cause of free, voluntary action by a free people has taken a step forward."—SHAWANO EVENING LEADER, May 24, 1952.

* * *

A Tonic for Good Will

"Wisconsin doctors are trying to compound a tonic for good will—good will toward the medical profession . . . Doctors representing the State and county medical societies are now turning to newspaper men, public relations experts and community leaders for advice.

"It isn't all up to the doctors and hospitals. If we are interested in better health services, we can learn a lot from asking doctors to talk to us and with us about these problems. Formation of local health councils, through which local doctors can help lay leaders examine and solve health problems, is one way. Boosting health insurance and voluntary health prepayment plans is another. Inviting doctors to speak to lay groups about health and medical profession problems will help eliminate many misunderstandings.

"The shortcomings of health services in Wisconsin are the fault of laymen as well as of doctors. Responsibility for better relations and better cooperation belongs to both."—MILWAUKEE JOURNAL, May 8, 1952.

Some Medical Aspects of Atomic Warfare

By ARTHUR L. VAN DUSER, M. D.
Madison

THE development of atomic bombs by hostile nations has placed the medical profession in the forefront of the defense of this country. However, many members do not adequately recognize this because they are unaware of or indifferent to the nature of the threatening military crisis. This unawareness or indifference is supported in part by the assumption that if war starts there will somehow be ample time, as in the past, for the mobilization of adequate medical resources and personnel. Such an assumption appears erroneous and not in keeping with the probable facts. The A-bomb has changed strategic patterns so that they bear almost no resemblance to those of the past. Tactically, cities with major industrial plants or populations are now at the "front." In time of war their populations will probably be under greater risks than those in the armed service. The power of the A-bomb is such that one should anticipate its military use to be by an initial surprise attack on all major production cities during a few days' time. Such an attack could seriously cripple a nation and cause upwards of ten million casualties. The ability of these "front line" cities to effectively recover will be directly proportional to the medical profession's ability to plan for and meet a massive emergency care crisis. Unpreparedness for such an emergency may well set off a chain of events resulting first in the collapse of these cities, and then in the nation.

The A-bomb does not produce traumatic or physiologic injuries that are uncommon to the profession. Its resulting medical problem is mainly the magnitude in numbers and the rapidity of occurrence of casualties. What then is the nature and number of casualties that result from a single A-bomb of the size used at Hiroshima or Nagasaki? It should be kept in mind that the A-bomb is essentially a heat bomb, with radioactivity. The explosion instantaneously creates and/or releases vast amounts of (1) radiant energies consisting of infrared, visible light, ultraviolet, and gamma rays, (2) radioactive fission fragment elements of numerous kinds and varying half lives, and (3) subatomic, neutron, alpha and beta particles. These substances manifest themselves as heat, light, ionizing or x-ray-like radiations, and blast forces.

TABLE 1—*Casualty Producing Agents*

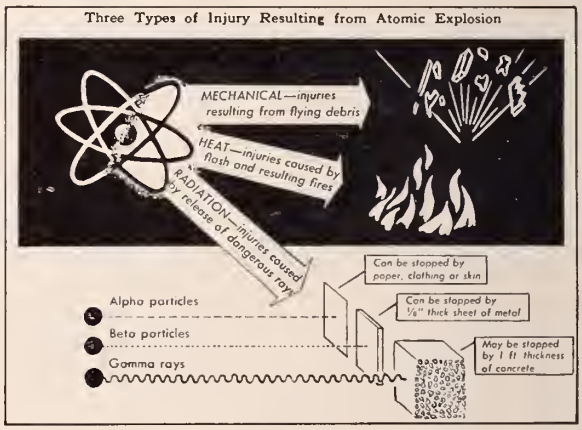
1. Heat—infra-red.
2. Light—visible, infra-red and ultraviolet.
3. Ionizing radiation—gamma rays, alpha, beta, and neutron particles.
4. Blast—results from rapidly expanding heated air.

The resulting effects and injuries therefore can be classified as being of thermal, traumatic, or radioactive nature, or a combination of these. On the average, a casualty will be suffering from more than one of these major types of injuries.

Thermal Injuries

Thermal injuries may be divided into *flame* and *flash* burns. Flame burns will be common among people caught in burning buildings. Radiant heat from the burst will cause many fires; others will occur from short circuits, overturned stoves, wrecked industrial plants, etc. The number of flame burns will depend in part upon the ability to control fires in a bombed area; in Hiroshima a "fire storm" developed.

Flash burns will occur among people exposed to the enormous pulse or flash of infra-red, visible light, and ultraviolet energies. These rays travel outward in straight lines like and with the speed of light. They last for only a second or two but because of their high temperature (4,000° C.) cooling cannot occur fast enough to prevent burns and fires. Such burns are oriented to the surfaces facing the blast. In the Japanese experience they accounted for about 90 per cent of the total burns seen and occurred out-



ward to a distance of 2½ miles from ground zero. At 2 miles the burns were first degree; at 1 mile or less, severe second and third degree burns predominated. The rays can be stopped by solid objects, excluding transparent material such as glass. Clothing affords a measure of protection, the degree depending on its thickness, color, looseness on the body, and nearness to the burst. Because dark clothing absorbs heat more readily than light, burn designs were common on the skin of Japanese wearing patterned clothing. Intense light of the flash, visible for over 200 miles, causes a "washing out" of the visual purple of the retina and resulting temporary blindness, usually of minutes' duration, in those viewing the burst.

Traumatic Injuries

Traumatic injuries may result from the *direct* and *indirect* effects of blast pressures. Direct blast pressure exceeding 35 pounds per square inch on the body or its openings can cause damage to internal organs. In Japan such injuries were rarely noted, and consisted mainly of ruptured ear drums. It is estimated that in an air burst at 2,000 feet, the pressures at ground zero approximate 50 pounds.

Indirect blast injuries due to collapsing buildings, falling timbers, and piercing missiles, particularly flying glass, would constitute nearly all of the traumatic injuries. These cover the gamut from minor scratches and bruises to severe perforation and crushing injuries. In the Japanese experience traumatic injuries of major significance were confined to within a radius of 2 miles from ground zero, although minor injuries, especially glass, were common at greater distances. Within the 1 mile radius of nearly complete destruction, the injuries were very severe. A paucity of fractures of the long bones, spine, and skull existed among Japanese survivors; however, these would probably be more common in the dead and in actively rescued survivors. The distribution of traumatic injuries by type seen at one Japanese hospital was fractures, 11.5 per cent; contusions, 53.8 per cent; and lacerations, 34.7 per cent.

Radioactivity

In the energy spectrum hard x-rays and soft gamma rays become one and the same. Their properties and biologic effects are therefore similar. Gamma rays are very penetrating and will enter or pass through body tissues leaving a trail of ionized atoms. The parent chemical elements such as sodium, hydrogen, oxygen, and others lose their electrical

The rubble at the right center is the only remains of Shima Surgical Hospital, Hiroshima, which was 100 feet from ground zero. The shell of the building at the right top center is Tada Hospital, which was located 2,600 feet from ground zero.

neutrality, resulting in changes in the complex chemical combination of proteins, enzymes, and other substances making up body cells. The net result of ionization when sufficient body area is involved is radiation illness or death. Susceptibility to radiation varies between species, members of the same species, and tissues. The most sensitive animal tissues are lymphoid, bone marrow, sex organs, and the lining of the gastrointestinal tract. The effects on these tissues although varying in time are reflected in the clinical picture produced.

TABLE 2—*Probable Effects From Total Body Irradiation*

Dose in Roentgens	*Probable Effect*
0-25	None
25-50	Detectable blood changes
50-100	Some injury, no disability
100-200	Injury, some disability
200-400	Injury, disability, some deaths
400 plus	Case fatality rate 50 per cent
600 plus	Case fatality rate 100 per cent

Persons subjected to a massive dose of 600 or more r, total body irradiation, have early nausea and vomiting (1 to 2 hours), prostration, and mild diarrhea. After a latent period of a few hours or days, intractable diarrhea, inflammation of the gastrointestinal tract, fever, and rapid emaciation uniformly cause death by the second week. In persons receiving moderately severe irradiation, 400 r, early nausea and vomiting are followed by a latent period of about one week. Symptoms similar to those noted in the 600 r group, plus delayed manifestation of serious injury to the vascular and hemopoietic systems, then become evident. Severe leukopenia with agranulocytic ulcerations and overwhelming systemic infections are common. Progressive anemia increased by purpura and hemorrhage occurs until recovery of hemopoietic centers. About half of this group may be expected to die, usually in the third to sixth week. In light to moderate doses of 100 to 300 r there may be no symptoms until the third week when epilation, pallor, petechia, mild diarrhea, weight loss, and anemia are among those manifested. There should be uniform recovery in this group in uncomplicated cases. In triage and mass treatment of casualties, nausea and vomiting on the day of bombing will be the most useful early indication of radiation illness. Recovery, when it occurs, from radiation illness is complete. Possible late effects in these casualties or their progeny appear to be minimal.

During the first minute or two of an atomic explosion, a vast amount of so-called *initial* gamma, neutron, and beta radiation is released. Because of the relatively short radius of neutron travel and the presence of superimposed lethal amounts of gamma, the latter is the only initial radiation warranting special comment here. Of the gamma radiation, 50 per cent is given off in one second, 80 per cent in ten seconds, and the remaining in two minutes. This travels outward with the speed of light in sufficient amounts to deliver a lethal dose of 600 r at less than 3,000 feet from ground zero, a medium lethal dose of 400 r at 4,200 feet, and a negligible dose of 20 r at 6,000 feet. An atomic explosion also produces many radioactive isotopes (fission fragments) of about 30 different elements, and releases unfissioned plutonium. These continue to "kick out" gamma rays and subatomic alpha and beta particles in their attempt to reach stability. When deposited on ground or other surfaces as would happen in ground or water level bursts, the isotopes and plutonium constitute a source of *residual* or contaminating radiation. In air bursts such bomb products are carried upward with the "fire ball" and dispersed in the atmosphere. Alpha and beta particles have far greater ionizing ability than gamma rays or neutrons; however, they penetrate poorly. Betas penetrate to the depth of the skin, and alphas are stopped by its superficial layers. The major hazard from these particles is that they may be deposited in body tissues through the ingestion of foods and water contaminated with products from the bomb. Areas of localized tissue injury, necrosis, tumor formation, and possible death would then result. In Japan the casualties were from initial, mainly gamma, radiation.

Number of Casualties

Estimates of probable total numbers of bomb casualties and their distribution by types are subject to criticism made valid by numerous involved factors of unpredictable variability. The vulnerable area from the medium-size bomb is a circle with a radius of two miles, containing about thirteen square miles. The number of persons at risk within such an area varies not with the size of the city but with its density of population per square mile. Major Midwest cities have densities in excess of 13,000; New York City averages 23,200 with a daytime peak of 145,000 in Manhattan.

TABLE 3—*Anticipated Atomic Bomb Injuries and Deaths—in Per Cent of Population Affected Within Half-Mile Zones*

Radius From Ground Zero	*Injuries*	*Deaths*
Within one-half mile	10	90
One-half to one mile	35	50
One to one and one-half miles	40	15
One and one-half to two miles	18	2

Some accepted data having a direct bearing on casualty estimates are compiled in table 3. Translating these data to an area of 13 square miles of an average Midwest city would produce an estimate of about 100,000 casualties. Of these about one-third would be killed outright or die within the first 24 hours. Additional but decreasing numbers of deaths would occur during the next six to seven weeks, with few thereafter.

It has been suggested that 70 per cent of all Japanese casualties had wounds, 65 to 85 per cent had burns, and over 30 per cent radiation injury.

Federal civil defense authorities estimate that in casualties surviving 24 hours, 60 per cent would have burns, 50 per cent wounds, and 20 per cent radiation injury. In a group of 65,000 to 70,000 initial survivors, of which many have more than one type of injury, one might therefore expect a minimum of about 40,000 burn, 35,000 traumatic, and 14,000 radiation injury cases. Of the initial survivors, approximately two-thirds (43,000 to 47,000) would require hospitalization with moderate to extensive amounts of medical care, and one-third could be given outpatient medical service.

It is obvious that casualties of this severity and volume would constitute a tremendous supply, hospital, and medical care problem that could be adequately met only through pre-emergency planning. It is equally obvious that the medical profession must be prepared to meet such a problem, as long as hostile nations have the A-bomb.

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SUGGESTED ITEMS FOR HOME FIRST-AID KIT FOR EMERGENCY USE

Civil defense home kits should be reserved for emergency use, and should be placed in that part of the home chosen as a shelter area. They should be used only for home emergency first aid, and until organized first aid is available. A suggested list of items, as compiled by the Federal Civil Defense Administration, is as follows:

1. Antiseptic Solution (such as Benzalkonium Chloride aqueous solution 1:1000)	3 to 6 oz. bottle
2. Aromatic Spirits of Ammonia, USP	1 to 2 oz. bottle
3. Baking Soda (Sodium Bicarbonate, USP)	8 to 10 oz. can
4. Bandage, muslin, triangular, compressed (37 x 37 x 52 inches, folded, with 2 safety pins)	Four packages, 1 each
5. Bath towels, large	Two
6. Bath towels, small	Two
7. Bed Sheets	One
8. Dressings, First-Aid Medium (8 inches by 7½ inches, folded, sterile with gauze enclosed cotton pads, muslin bandage and 4 safety pins)	Two packages, 1 each
9. Dressing, First-Aid, small (4 inches by 7 inches, folded, sterile, with gauze enclosed cotton pads, gauze bandage)	Two packages, 1 each
10. Drinking Cups, paper, envelope	25 to 50
11. Emergency Eye Drops (Castor oil, USP)	Half to one oz. bottle
12. Flashlight, with extra batteries	
13. Pins, safety, medium (1½ inch in length)	10 or 15
14. Razor Blades, single edge	2 or 3
15. Salt and Soda Tablets (Sodium Chloride, 10 gr., Sodium Bicarbonate or Sodium Citrate, 5 gr.)	Bottle of 100 to 200
16. Soap, Toilet	1 or 2 cakes
17. Splints, ⅛ to ¼ in. thick by 3½ inches wide by 12 to 15 inches long, plastic, basswood or household material	Two or three
18. Tongue, blades, wooden	12 to 15
19. Water Purification Tablets Halazone or Iodine Compound	Bottle of 100

While the purpose of many of the above items is self-explanatory, the following notes will serve as a guide to the use of others:

1. Any suitable *aqueous* antiseptic may be used in place of the one suggested. It is to be used on open wounds, not burns.

2. Ammonia Spirits may be used for fainting or near collapse, either internally or by inhalation. Internally, for adults, use ½ teaspoonful to glass water; for children, use 5 to 10 drops in a little water.

3. Baking soda furnishes a measure of protection against nerve gas in two ways. Add 2 ozs., or about 4 level tablespoonfuls, to one quart of water and use to wash parts of body exposed to nerve gas, or saturate a cloth with this same solution and use as a face mask for protection against inhalation of nerve gas.

The Physician and Civil Defense Planning in Wisconsin

By M. J. MUSSER, M. D.
Chairman, Committee on Civil Defense
Madison

CIVIL defense has become a permanent part of our state and federal governmental functions. Its purpose is the organization and mobilization of all civilian resources necessary to deal with the devastation to life and property which might result from any disaster caused by natural or man-made forces arising from within or outside the United States. From a purely military standpoint, civil defense has two objectives. The first is to help maintain world peace by making it obviously unprofitable for an enemy to attack us on the home front. The second is to minimize the effectiveness of an attack, if it does come, by saving lives, relieving suffering, maintaining production for the armed forces, and assuring a sustained high level of morale.

People have always lived in the face of threatening situations and in more or less of a state of continued conflict. Until the past decade, we enjoyed the protection of natural barriers and derived considerable security from the predictability as well as the limitations of existing means of waging war. We no longer live under such favorable conditions. Now, because of the tremendous advances in atomic weapons, guided missiles, and aviation, there are no protective barriers and the devastation which enemy attacks might cause is without limitation and beyond ordinary comprehension. Heretofore, in wars, only the combatant felt the full impact of the threat to him as an individual. Now, the civilian must share in that threat and, because many of our cities are such important and vulnerable military targets, civilians may well suffer the major onslaught of an enemy attack and sustain even greater casualties than the armed forces. Never before in the history of warfare involving this country has the individual civilian been as vulnerable as he is now. Never before has security and survival depended so much upon the coordination of individual and collective efforts of the entire population.

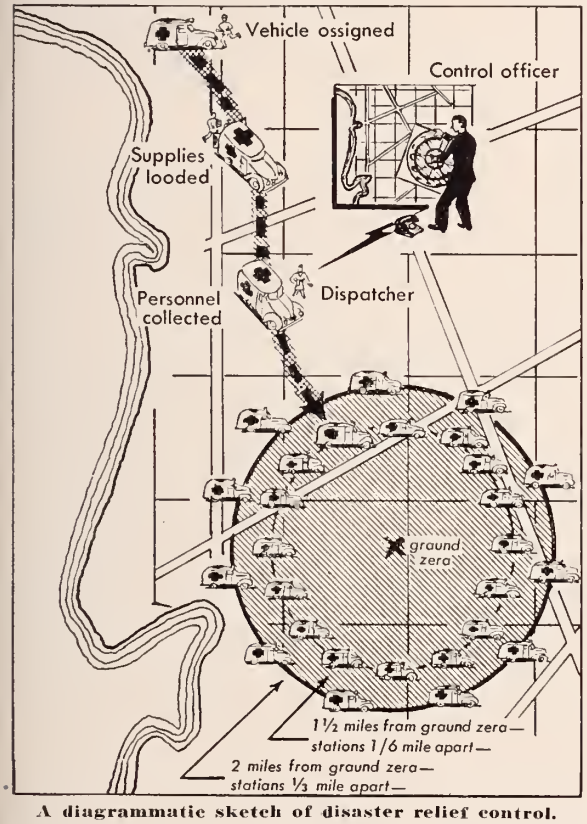
The threat of an atomic disaster in Wisconsin is completely uncertain and unpredictable. Yet, as long as the existing chaotic world situation remains and enemies continue to arm themselves with more and more formidable weapons, the threat persists. In the event of war, the use of atomic bombs would be certain, and the use of agents of biologic warfare would be possible. Subversive activities with their potentialities for creating great havoc would be widespread. We would be ill advised indeed if we did not pay heed to the circumstances and possibilities as they exist and mobilize such resources for our defense and protection as are necessary. This can be accomplished realistically and effectively if every one assumes his share of the responsibility. Only the uninformed and unthinking can enjoy the refuge of complacency. Panic is fostered by ignorance, unpreparedness, and an unwillingness to accept the responsibility for one's protection. There must be no panic!

Because the threat which exists is so unpredictable and uncertain, the plan to meet it must be sufficiently flexible as to be adaptable to any situation. It must be adequate to quickly and effectively take care of a small number of casualties in a small community, yet also adequate for expansion to care for an unprecedented number of casualties without impairment of efficiency or unnecessary loss of time. Twenty to forty thousand casualties cannot wait! There is no single organization which can undertake to provide all of the facilities which will be required. The task is one which will require the coordinated efforts of large numbers of well trained, well informed, and adequately equipped individuals. Every community has a contribution to make.

In the event of an enemy attack, atomic or otherwise, it is intended that the civil defense authorities in the stricken community will immediately appraise the situation and institute pre-planned relief measures. The State Civil Defense Director will be notified of the magnitude of the disaster and the need for assistance. The second echelon of relief will be the resources, equipment, and personnel of neighboring communities. As the need exists, more distant facilities can be systematically mobilized, so that, if necessary, the entire potentialities of the state, supplemented by federal support, can be utilized.

Following an atomic bomb explosion, the magnitude of the problems within the disaster area will be tremendous. Debris must be cleared and fires extinguished before casualty removal can begin. The thousands of dazed, panic-striken, and homeless must be guided to safety and provided with shelter, food, clothing, and water. Radiation discipline must be established. Law and order must be maintained. Hundreds of litter bearers and first-aid workers in conjunction with demolition and rescue teams, must seek out the thousands of wounded and transport them to the aid stations. The bodies of the thousands of dead must be removed, identified, and disposed of. Only with precisely organized and maintained traffic control can essential relief elements and supplies be moved into the area and casualties be expeditiously evacuated. Within the aid stations, established at predesignated locations, in excess of 500 casualties in a 24 hour period must be sorted, provided with basic treatment, and prepared for evacuation. A steady flow of them in and out of the station must be accomplished. Some who cannot be transported

will be transferred to adjacent improvised casualty holding stations. These will include those who have received lethal doses of radiation. Shelter and facilities for care of ambulatory and psychiatric casualties will be necessary. The evacuees to hospitals must be taken to ambulance loading points, and there, as expeditiously as possible, loaded into evacuation vans or other conveyances and systematically dispatched to the nearest available fixed or auxiliary hospital. At these loading points, shelter must be provided since the evacuation of casualties will by necessity be extended over a period of several days. Points of destination must be well designated to prevent excessive crowding of hospitals. Throughout, accurate records must be kept, information centers operated, and an adequate system of communications maintained. Probably the actual emergency care and evacuation of casualties, depending upon their numbers, will continue for upwards to one week. Thereafter, radiation sickness will be the chief problem with which to deal. However, temporary hospital facilities will have to be continued for several weeks and the operation of fixed hospitals at emergency capacities will be necessary for even longer periods. This will be especially true if repeated attacks occur. Indeed, few of us have any concrete idea of the enormous medical and health problems that we would face.



A diagrammatic sketch of disaster relief control.

Adequate civil defense measures are our only means of coping with the situation. It is estimated that with warning of an enemy attack, proper individual and collective defense measures will reduce the number of casualties by 50 per cent. It becomes clear why in civil defense planning the principles of self-help have been emphasized. Each individual must know what protective action to take and also how to minister aid to others. He must be familiar with the civil defense plan of his community and his assigned role in it, so that in the event of a disaster he can contribute constructively to the relief effort.

Beyond the individual, communities must assume responsibility and organize their resources and train their citizens for their own protection. Civil defense plans will vary considerably in accordance with the potentialities of the community as a military target. Every community must be prepared to assist stricken areas. This mutual assistance principle is the basis for planning in rural localities. It is obvious that a certain degree of uniformity in basic planning and operations is essential. Efforts to accomplish this have been made in meetings of mayors and local civil defense authorities with the state civil defense director.

The State Office of Civil Defense has been established to provide a basis for the planning and coordination of efforts and resources. From it should come the delineation of responsibility and the establishment of a mutual understanding of authority, functions, and operations of the various local, state, federal, public, and semi-public agencies or organizations whose resources are necessary to provide civil defense needs. A co-director for health services is responsible for medical matters.

To enhance coordination of inter-community and state efforts and to expedite the mobilization of relief facilities, the State has been divided into eight defense areas (see map), each with a civil defense and a medical director. These individuals will assist communities with their planning and will regulate mutual relief activities in the event of a disaster. Within each area, and as a part of the state civil defense organization, there has been organized a mobile defense battalion composed of all the elements necessary to supplement a community's relief efforts. While units comprising these battalions will be located in various communities within the area, they will not be considered as a part of the community's independent civil defense organization. They will serve within their community, however, in the event it should suffer an attack. Primarily, the responsibility of the units of the battalions is to organize, train, and equip themselves to move, upon notice, as rapidly as possible to any disaster area within the state and there become a part of the relief effort. In the eight mobile defense battalions, there are a total of 100 medical aid units, each identical in organization and basic equipment. These, when called upon, will supplement community units and will render emergency treatment to casualties and initiate their evacuation to hospitals. When the need exists, some of these units will operate casualty holding stations, ambulance loading points, and

auxiliary hospital establishments. Their organization is such that they can be augmented with technical personnel and equipment to broaden the scope of their functional abilities. They are the key to the success of the medical relief efforts.

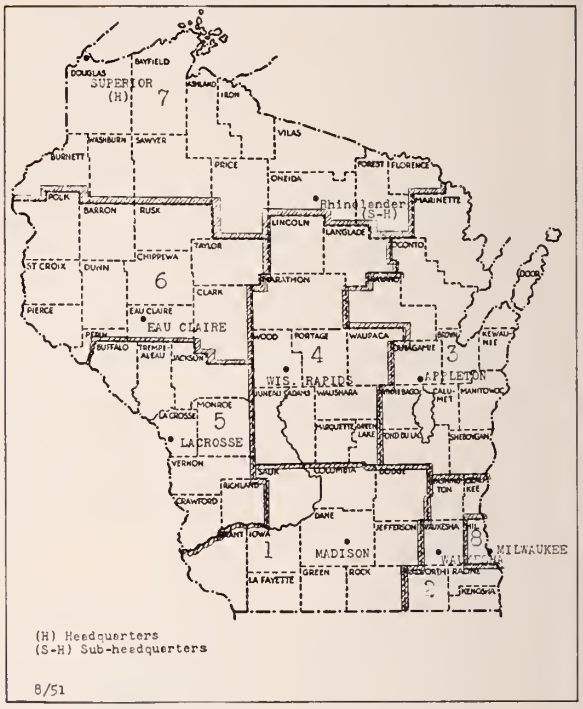
The responsibility of the medical profession in civil defense is tremendous. The challenge can be met only by the wholehearted support, interest, and cooperation of all physicians. Each has something to contribute, and in the event of an enemy attack, each will have a job to do.

It is the responsibility of every physician to be cognizant of the civil defense plans of his community and of the state and of the exact part he is to have in them. He should acquaint himself with recommended procedures of treatment of atomic disaster casualties. Adequate knowledge of and training in his specific civil defense duties is essential to assure maximum use of his professional skill in the event of a disaster. He should encourage, and, if necessary, assist in the training and organization of the large number of nonprofessional individuals whose services will be of critical importance in caring for the thousands of disaster casualties. His interest and activities in civil defense can do much to dispel the apathy and indifference which exists in so many communities. Probably there is no single individual who can have such important influence upon the general public.

County medical societies have a vital role in civil defense. They provide a splendid medium for the presentation and discussion of pertinent instructional material and the coordination of planning and training for physicians of adjacent communities. Their organization and functions are such as to ideally fulfill the need for liaison between state, county, and community civil defense activities. It has been recommended that each county medical society establish a civil defense committee which should function in an advisory capacity to community and area authorities and which should also inform the State Society of existing medical problems relating to civil defense. It is within the province of the county societies to take such steps as are necessary to assure that the communities which they represent have realistic and adequate civil defense programs. There probably is no more effective way of creating public confidence in the civil defense system or of preparing the public for what atomic warfare might bring, than to have the physicians of the state, individually and through their society, work hand in hand with civil defense authorities; and in this way to let the public know that in the event of an atomic disaster, the physicians really are ready.

Since the establishment of a civil defense program in Wisconsin, the State Medical Society has worked closely with the civil defense director and his co-director for health services in the formation of medical plans and policies. It has undertaken to assess the medical resources of the state so that they can be used with maximum efficiency. In fulfilling its responsibility to the physicians of Wisconsin, it has attempted to keep them appraised, through their county societies, of the status of civil defense in the state. It is hoped that this issue of the Journal will clarify any questions or misunderstandings which might exist.

WISCONSIN CIVIL DEFENSE AREAS



Much remains to be done in the establishment of a civil defense organization in Wisconsin which will operate effectively in the event of a disaster. In many respects, only the surface has been scratched. If an enemy should attack us tomorrow, we would be able to mobilize a fairly formidable disaster relief organization. However, because of insufficient training, undependable personnel, inadequate equipment and supplies, and the confusion which would result, its efficiency would be seriously impaired. Many casualties would die unnecessarily. Such a situation must not be allowed to persist. One cannot help but wonder how the people of Wisconsin would react if we were to be attacked tomorrow. There is much reason to believe that they must be far better informed and instructed than they are at present before they can confidently assume the tremendous responsibilities which will be theirs. One cannot help but wonder how well prepared the communities of the state are. Can they be depended upon to effectively cope with a disaster or provide a maximum of relief to another community? It is hoped that the answers to these questions will not have to await an enemy attack. The full responsibility for that development of an adequate civil defense organization in Wisconsin is not ours as physicians, but we have a vital contribution to make, and we cannot relax until it has been done.

How A Mobile Medical Team Functions

By CARL N. NEUPERT, M. D.
Co-Director, Health Services Division, Wiscansin Civil Defense
Madison

SOON we will be prepared to care for as many as 20,000 Wisconsin people who might be critically injured in a single air attack. This could well happen. If such an attack comes, we can anticipate additional attacks, possibly in rapid succession. Our job is to reduce to a minimum the suffering and deaths from such an attack. Never before have we faced so enormous a catastrophe.

No city could be expected to meet such an emergency without a good deal of outside help. As much as two-thirds of the hospital facilities and two-thirds of the doctors and nurses in a stricken city could be wiped out by a single A-bomb. Paralysis due to fear and shock can be expected to interfere with the efficiency of the remaining one-third during the first few hours following attack, so that such a city would be quite unequal to the task on its own.

Since we have no way of knowing where the blow will strike, and since wherever it does there will be urgent need for outside assistance, mobile battalions have been organized throughout the state, ready to go to any stricken city in the state or even to a city in a neighboring state, should that become necessary. One hundred medical casualty teams have been organized with varying numbers of them in each of the eight battalions covering the state. Each battalion includes transportation, communications, fire fighting, and police units in addition to medical teams. This is to insure getting to the injured in an orderly fashion, prepared to care for them, and to prevent further casualties due to fires and other causes.

Each medical team consists of 29 members headed by the team captain (medical director) and his deputy, also a physician. The balance of the 29 are two dentists, two nurses, a business manager, two medical corpsmen, eight first-aid personnel, four first-aiders with radiologic training, four stretcher bearers, one carpenter (also trained in first aid), a mechanic (truck driver), and two clerks to keep records.

Two or more teams can be assigned to the same casualty station in one building. They are subject to call only in a major emergency, on declaration by the Governor that such an emergency exists. In response to the call to duty, they assemble at a predetermined place in their own community to be transported as a team in a bus to an assembly point (also predetermined) at the periphery of the city that has been hit. From there they proceed by teams under the direction of the civil defense director of the stricken city to their designated station, a building such as a school or a church. The team's truck goes with it. Supplies for the first few hours' need will be on the truck or on other trucks sent to meet them, depending on the specific arrangements. Additional supplies will be available from federal stockpiles. Funds for procurement of the necessary emergency supplies including cots, plasma, drugs, dressings, splints, and other items, have been provided by the legislature and the emergency board, with the approval of General Ralph J. Olson, State Civil Defense Director and his Advisory Board. Except for a small portion, purchase is on a fifty-fifty matching basis (state and federal funds) through the Federal Civil Defense Administration.

Local civil defense organizations in target cities are responsible for rescue service, that is, bringing the patients to the casualty first-aid station. The medical teams take over on admission to the casualty first-aid stations. Teams are organized, much as has been found practical in comparable military units, so that patients are tagged on admission and promptly classified as to their need of treatment. The three main groupings are those slightly, seriously, or mortally wounded. This is covered in the special manual for operation of mobile medical teams, available to each member of the teams. Those mortally wounded fall in priority A–1 including: (1) massive hemorrhage, (2) extensive open wounds such as chest wounds, abdominal wounds, head and spine injuries, (3) extensive third degree burns and burn cases in shock, (4) fractures, (5) obstetrical emergencies (6) severe hysteria and temporary psychoses, and (7) moderately severe and severe shock from any cause. All other patients would be classified as either A–2 or A–3; the A–2 being seriously injured cases which would require eventual evacuation to a hospital, and A–3, those with lesser burns or injuries which could be evacuated to their homes or to local residences. The team organization manual points up the internal organization and duties of members of surgical and medical teams. The Emergency Treatment Manual outlines treatment for burns, shock, crushing injuries, extensive open wounds of the chest, abdomen or other parts, fractures, radiation casualties, and pyschiatric casualties. These manuals were prepared and approved by the Committee on Civil Defense of the State Medical Society, composed of physicians with medical combat experience in World War II. The committee is under the chairmanship of Dr. Marc J. Musser of Madison.

While it would have been desirable to have mobile emergency hospitals that could be brought to the vicinity of the casualty areas, none was procurable. Therefore, it was agreed by the advisory com-

mittee that patients needing hospital facilities would be transported from the casualty first-aid station to existing hospitals within approximately 80 miles of the disaster. These hospitals are to provide auxiliary facilities in suitable buildings nearby to enlarge their capacity to receive the wounded. Patients who could be more safely transported to other hospitals more distant by the next day would be moved on to them to make room for additional casualties from the disaster area. Evacuation is to be primarily by large van, although evacuation by railroad in selected cases is a definite possibility.

A manual covering hospital treatment of casualties has also been prepared by the Committee on Civil Defense to provide participating hospital boards and staffs with basic data on needed equipment and supplies for a 100 to 200 bed hospital. This enables hospitals to stockpile in readiness for the impact of disaster casualties. This manual is quite complete and specific, dealing with fractures, shock, wounds, craniocerebral and spinal injuries, psychiatric casualties, radiation syndrome, and casualties caused by biologic warfare.

Blood and plasma procurement is being worked out by a special subcommittee whose members are representatives of the Junior League Blood Bank of Milwaukee, the Wisconsin Blood Bank Association, the Wisconsin Association of Pathologists, the Wisconsin and Catholic Hospital Associations, and the State Medical Society, under the chairmanship of Mr. Howard D. Marlin, state relations representative of the American Red Cross. The Committee on Civil Defense of the State Medical Society faced reality when it held that in the casualty stations, it would be impractical to attempt to do crossmatching and grouping for transfusions and that therefore only type O blood would be used for cases needing whole blood. Accordingly, it has been necessary to arrange for making available to hospitals and other bleeding centers throughout the state lists of known type O blood donors to be called on for donations in time of emergency. Stockpiling of whole blood is not practical in the quantities needed. Approximately 45 per cent of all donors are in the type O group. Type O blood on hand in the two major blood banks in the state and in any cooperating hospitals will be available immediately and can be expected to arrive very shortly after the teams arrive. The balance of the needed supply will be in process of procurement on a 24 hour shift basis by the trained teams of bleeders.

Plasma will be stockpiled. Dried plasma has a five year period of usefulness, thus insuring against out-dating when coupled with a use and replacement program being worked out.

The tremendous undertaking of organizing, training, and providing needed supplies for 2,900 civilian volunteers (29 per team for 100 teams) is well along toward completion, because of the conscientious sacrifice of much time, energy, and money out of the pockets of all these people. The doctors have the chief responsibilities, and on their shoulders

Trucking firms are prepared to convert large vans for evacuation of casualties.

rest the major elements of success, since they alone have the technical training to give over-all supervision of the medical care of the injured. However, they would be helpless in a disaster of this magnitude without the help of dentists, nurses, corpsmen, and first-aiders. Effectiveness is dependent on teamwork of the entire group. The business manager is an important member of the team on whom its success is dependent for recruiting, arranging for training, and keeping things operating efficiently. The carpenter and the mechanic are indispensable, as are the two clerks on whom we must depend to see that tags record morphine given, identity of patients, their diagnosis and treatment. First-aiders and stretcher bearers take full courses of first-aid training to make possible replacements and shifts of duties within the team. The radiologic monitors take special training in that field in addition to first aid to provide the patients and the team protection against radiologic exposure. They are also available to rescue squads working in the vicinity. Together, as a unit, the team is prepared to fulfill its mercy mission, each doing his part of the whole job.

All the way through, all of us have concentrated on keeping expenditures to a minimum. Only those supplies have been provided that were found necessary to give essential treatment. In keeping with that concept, the Civil Defense Committee of the

Society recommended that supplies for training purposes be improvised in preference to laying out public funds to purchase training supplies that could not be used subsequently for care of casualties. Their suggestion was to use torn sheets for bandages and slings, boards for splints, and improvised substitutes for other equipment. In some communities, women's organizations, service clubs, or public spirited individuals who could make no other direct contribution to the program have been appealed to as sponsors to provide substitute training supplies.

At present, all of the work of organization and training has been taken on as an extra assignment in the public interest, beyond the demands of regular duties, by all participating. No full time staff in civil defense has been assigned to the Health Services Division, even though need for a full time field man is recognized and provided for as soon as one can be procured. The State Medical Society has been especially helpful as have been staff members of the State Board of Health.

So far there has been only brief mention of the organizational setup. Each medical team is part of one of the eight battalions. The teams in each battalion are responsible to an area medical co-director. Area III in the northeastern part of the state—the largest area—is divided into three divisions with a medical co-director for each. The area medical co-directors are responsible for the medical teams under their direction and for coordinating and assisting local civil defense health directors in city or county setups in their area. They are responsible for selecting replacements of team captains who may resign or become disabled and for seeing that the teams are fully recruited, trained, and ready. Orders for mobilization are executed through them. They are members of the cabinet of the battalion director for planning and executing plans for the medical teams of the battalion.

They in turn are responsible to the health services co-director in the state setup of which General Olson is civil defense director. General Olson, in turn, is directly responsible to the Governor.

Often the question has come up as to the relationship of these state mobile medical teams to local civil defense organizations. Are they in any way available as part of the local program? In many communities these same medical teams are also casualty first-aid teams in the local organization, with the understanding that they are available for call to outside service as part of the state mobile system in cases of major emergency when a state of emergency has been declared by the Governor. Even in the event a state of emergency is declared, if it involves the city in which these particular teams reside, they will not be called out. Instead, other mobile teams will be brought to that stricken city's assistance. The welfare of the citizens in any one city in Wisconsin is just as important as that of any other. It is for this precise reason that mobile teams have been organized in all parts of the state to insure prompt help from those nearby to be augmented as needed from other areas.

Teams will be called in waves or echelons as they are needed, with those nearest being called first.

A description of the functions of medical teams would be incomplete without giving recognition to one of our most stressing problems, namely, the difficulty of keeping teams fully recruited over a long period. Resignations due to moving, illness, death, and other causes are only a part of the problem. Lack of conviction on the part of many that there is a need for these teams or for any civil defense constitutes the greatest obstacle. The fact that we may need to be in a state of preparedness for some years to come, when we may be at neither peace nor war, complicates it still further. To wait until the first bomb has been dropped is unthinkable since, if one of our Wisconsin cities is hit, we will doom to needless death possibly thousands of our own who could have been saved had we been prepared. To assume that cities in other states will be the first is too risky in view of known probabilities. As for that, catastrophes in neighboring states, should they need our help, are of immediate concern to us, too. Should this country become involved, it will not be a series of unrelated incidents of minor concern to us, but rather a struggle for survival of us all with the fate of Detroit or Chicago just as vital a matter as that of one or more of our own cities.

So, like it or not, immediately imminent or not, we can do no less than be as ready as possible to administer to the injured when, or if, such a disaster comes to pass. Should we fail, for want of getting as ready as we can, the medical profession would lose its high place in the regard of our fellow citizens.

PHYSICIANS REMINDED OF NARCOTICS REGULATION

By July 1, all physicians registered under the Harrison Narcotic Act or under the Marihuana Tax Act must have effected reregistration. Very severe penalties may be invoked in case of failure.

If you have not received forms for separate registration and inventory of narcotics and marihuana, write immediately to the office of the Collector of Internal Revenue, Federal Building, Milwaukee 1. It is the responsibility of the physician to effect reregistration, make out inventories, and pay the annual tax or taxes. Physicians having two offices *must* register for both, as each office must have a separate registration number. Physicians in service are exempt.

Roster of Mobile Medical Team Captains*

Area I

Charles K. Kincaid, M. D., 110 North Hamilton Street, Madison, medical director.

R. H. Gunderson, M. D., Beloit
C. M. Carney, M. D., Beloit
O. H. Hanson, M. D., Ft. Atkinson
T. C. H. Abelmann, M. D., Watertown
P. J. Lawrence, M. D., Madison
L. E. Holmgren, M. D., Madison
J. T. F. Gallagher, M. D., Madison
C. A. Fosmark, M. D., Madison
E. H. Grumke, M. D., Madison
T. J. Nereim, M. D., Madison
N. M. Clausen, M. D., Madison
J. G. Waddell, M. D., Madison
D. L. Williams, M. D., Madison
R. F. Schilling, M. D., Madison
J. J. Lalich, M. D., Madison
H. C. Johnson, M. D., Madison
E. F. Tierney, M. D., Portage
A. C. Edwards, M. D., Baraboo
Nathan E. Bear, M. D., Monroe
S. A. Freitag, M. D., Janesville
E. W. Reinardy, M. D., Janesville
C. R. Gilbertsen, M. D., Janesville

Area II

Ellison F. White M. D., Wisconsin State Sanatorium, Statesan, medical director.

E. E. Bertolaet M. D., Elkhorn, deputy medical director.

J. C. Coon, M. D., Racine
H. G. Brehm, M. D., Racine
W. E. Buckley, M. D., Racine
John Docter, M. D., Racine
A. M. Lindner, M. D., Racine
G. L. Rothenmaier, M. D., Racine
Elizabeth N. Steffen, M. D., Racine
David Baker, M. D., Burlington
George Skow, M. D., Racine
C. M. Creswell, M. D., Kenosha
J. P. Graves, M. D., Kenosha
C. E. Pechous, M. D., Kenosha
A. M. Rauch, M. D., Kenosha
G. C. Schulte, M. D., Kenosha
H. L. Schwartz, M. D., Kenosha
Joseph Bartos, M. D., Waukesha
Gwilym Davies, M. D., Waukesha
A. F. Rogers, M. D., Oconomowoc
B. J. Werra, M. D., Waukesha
George Savage, M. D., Port Washington
H. J. Kenney, M. D., Delavan

*This roster includes all team captains appointed as of May 15, 1952.

Area III

G. M. Shinners, M. D., City Hall Annex, Green Bay, medical director of Division A.

G. B. Merline, M. D., De Pere
C. S. Bolles, M. D., Green Bay
Bernard Kulkoski, M. D., Green Bay
John Goelz, M. D., Green Bay
E. R. Killeen, M. D., Green Bay
J. F. McDermott, M. D., Green Bay
R. J. Rose, M. D., Green Bay
J. C. Pinney, M. D., Sturgeon Bay
Clark Boren, M. D., Marinette
K. J. Moss, M. D., Marinette
A. F. Slaney, M. D., Oconto
J. W. Christofferson, Shawano

John S. Wier, M. D., 80 Sheboygan Street, Oshkosh, medical director of Division B.

J. P. Canavan, M. D., Neenah
J. E. Conway, M. D., Menasha
Lynn Simerl, M. D., Menasha
W. S. Giffin, M. D., Appleton
A. J. Gloss, M. D., Appleton
Milo Swanton, M. D., Appleton
Stanley Graiewski, M. D., Oshkosh
Reuben H. Bitter, M. D., Oshkosh
R. F. Wagner, M. D., Oshkosh
W. H. Schuler, M. D., Ripon
Harmon H. Hull, M. D., Waupun
L. J. Keenan, M. D., Fond du Lac
A. M. Hutter, M. D., Fond du Lac
R. L. Waffle, M. D., Fond du Lac

Roman C. Pauly, M. D., 1501 South Twelfth Street, Sheboygan, medical director of Division C.

B. F. Eckardt, M. D., Sheboygan
E. T. Hougen, M. D., Sheboygan
H. J. Winsauer, M. D., Sheboygan
N. C. Erdmann, M. D., Manitowoc
G. M. Hoffman, M. D., Manitowoc
R. G. Strong, M. D., Manitowoc
R. E. Martin, M. D., Two Rivers

Area IV

Erwin P. Ludwig, M. D., 502 Third Street, Wausau, medical director.

R. B. Larsen, M. D., Wausau
J. V. Flannery, M. D., Wausau
W. T. Becker, M. D., Wausau
F. W. Reichardt, M. D., Stevens Point
E. C. Glenn, M. D., Wisconsin Rapids

Area V

Paul C. Dietz, M. D., 1020 Market Street, La Crosse, medical director.

A. J. Harris, M. D., Sparta
M. T. O'Meara, M. D., La Crosse
P. W. Phillips, M. D., La Crosse

R. W. Ramlow, M. D., La Crosse
L. R. Schmidt, M. D., La Crosse

Area VI

John W. Wishart, M. D., 314 Grand Avenue East, Eau Claire, medical director.
R. M. Lotz, M. D., Eau Claire
H. E. Sorensen, M. D., Eau Claire
E. J. Hatleberg, M. D., Chippewa Falls
W. C. Henske, M. D., Chippewa Falls

Area VII

Victor E. Ekblad, M. D., 1507 Tower Avenue, Superior, medical director.
H. B. Christianson, M. D., Superior
Milton Finn, M. D., Superior

Area VIII

Carl G. Dunst, M. D., 1912 East North Avenue, Milwaukee, medical director.
C. A. Bauer, M. D., Milwaukee, director of casualty collecting stations.
Captains of Casualty Collecting Stations
J. F. Cary, M. D., Milwaukee
A. J. Baumann, M. D., Milwaukee
A. A. Krygier, M. D., Milwaukee
C. L. Budny, M. D., Milwaukee
S. E. Zawodny, M. D., Milwaukee
L. M. Boxer, M. D., Milwaukee
R. G. Gallimore, M. D., Milwaukee
T. J. La Susa, M. D., Milwaukee
F. A. Ross, M. D., Milwaukee
G. J. Worm, M. D., Wauwatosa
B. J. Peters, M. D., Wauwatosa
Vito Guardalabene, M. D., Milwaukee
D. S. Thatcher, M. D., Milwaukee
R. W. Mann, M. D., Milwaukee
F. J. Stoddard, M. D., Milwaukee
L. R. Weinshel, M. D., Milwaukee
Ervin Hansher, M. D., Milwaukee
D. W. Ovitt, M. D., Milwaukee
F. J. Mellencamp, M. D., Milwaukee
J. S. Devitt, M. D., Milwaukee
H. W. Pohle, M. D., Milwaukee
M. C. F. Lindert, M. D., Milwaukee
Frederick Bunkfeldt, M. D., Milwaukee
W. F. Hovis, Jr., M. D., Milwaukee
E. B. Gute, M. D., Milwaukee

SUPPLIES BEING PROCURED FOR MEDICAL MOBILE TEAMS

The following is a list of supplies which are being procured for the use of the state's mobile medical teams:

Medical Supplies

Airway, hard rubber, large and small
Alcohol, denatured, qt. size
Bandage, gauze, 2" x 6 yds. 12 s.
Bandage, muslin, triangular
Blade, operating knife
Brush, hand
Compress & Bandage, 22 x 36 and 22 x 18
Cotton, absorbent, 1 lb.
Depressor, tongue, wood, 100 s.
Dressing, first aid, large
Forceps, dressing spring smooth
Forceps, tissue, spring teeth
Forceps, hemostatic, straight
Forceps, hemostatic, curved
Forceps, tongue holding
Gauze, 36 x 100 yds.
Handle, operating knife
Matches, safety, 10 s.
Merthiolate solution, pt. size
Needle, hypodermic, 20 gage and 25 gage
Needle, suture catgut and suture skin
Pencil, indelible, 12 s.
Pencil, skin
Pentobarbitat sodium tablets
Pins, safety, large 12 s.
Plaster, adhesive 3" x 5 yds.
Procaine hydrochloride and Epinephrine tablets, 100 s.
Retractor, gen. operating
Scissors, bandage 7¼", dissecting 5½" & dissecting blunt
Soap, toilet milled
Splint, basswood 12 s.
Sponge, surgical 4 x 4
Suture, surgical gut and dermal medium
Syringe, 10 cc.
Tags, identification, 20 s.
Towels, hand paper
Aureomycin hydrochloride 100 x.
Procaine penicillin in oil, 300,000 units per 10 cc.
Liquid blood plasma, O type blood
Boric acid opthalmic ointment 5%, ⅛ oz., no. 24
Atropine Opthalmic ointment 1%, ⅛ oz., no. 10
BAL ointment (standard) 100 Gm.
Atropine syrettes (Ampins) 2 mg.
Morphine tartrate syrettes 0.015 Gm. and 0.030Gm.
Pot. Mercury Iodide Disc. P.D. (Antiseptic tablets)
Bed pans (White enamel)
Trays (sterilizer with cover) 28½" x 10"
Paper, toilet (rolls)
Applicators, wood, Box
Lantern, gasoline
Pads, heating (chemical B & B)
Pads, chemical (refills)
Cans, corrugated, cover, 10 gal.
Tourniquets

Other Supplies

Litters and litter cots
Blankets will be purchased by requisition by prior arrangement in time of emergency

Milwaukee County Medical Civil Defense Plan

By CARL G. DUNST, M. D.
Chairman, Medical Care Services, Medical Society of Milwaukee County

APPROXIMATELY two and one-half years ago, through a simple change of committee designation, the first-aid committee of the Medical Society of Milwaukee County became the first-aid and civil disaster committee charged with the task of organizing medical emergency services for the county in the event of civil or military disaster. In addition, the committee was charged with organizing mobile medical services for the relief of areas outside the county and the state in event of military disaster. These changes were prompted by the knowledge that the conflict then starting in Korea was supported by the communists and could easily lead to an open break with Russia. The United States had proved with reasonable certainty that Russia not only knew how but was producing atomic bombs. Experience in Japan with this new weapon had proved the magnitude of its destructiveness. For a little while, we had enjoyed an immunity from its ravages. Now with a potential enemy in full possession of all the knowledge necessary for its manufacture and use, we were confronted with the problem of building a defense against its horror.

The introduction of the atomic bomb had completed a cycle in warfare which began when our cavemen ancestors were faced with the problem of defending their homes with a club, or using concealment to escape their enemies. As warfare became more specialized, the home, the town, and the city, unless it happened to be in the pathway of war, escaped its ravages and inconveniences. Business went on as usual.

Today, while the club is no longer of any value in defense, a place of adequate concealment is paramount. War is again at our door-step.

With these facts conclusively before us, the leaders in our country attempted to develop a program of civil defense. Again we were confronted with the age old problem, which should come first, the chicken or the egg?

The federal government was slow to take the initiative in establishing precedents for states and cities to follow in developing a useful, well integrated civil defense. In place of being given a well tested, practical program to act as a model, each tiny hamlet, city, and state was obliged to organize what each thought was an adequate plan. Then, through trial and error, and by mutual exchange of ideas, something gradually evolved that exhibited a degree of integration and practicability.

This too was the situation of organized medicine and its allied professional and semi-professional branches two and one-half years ago in Milwaukee County. Given the task of planning a suitable medical defense, with all its ramifications, for the County of Milwaukee, the first aid and civil disaster committee was in a situation no different than that of hundreds of other similar committees throughout the United States.

With little experience, save that of World Wars I and II to be guided by (and that experience of little use because of the entirely different problem), the committee began to formulate a program which it thought would adequately serve the needs of the people in our community. This involved the establishment of a plan for medical services from the time the casualty is removed until his evacuation to a place for definitive treatment.

First, it was necessary to determine roughly the magnitude of the problem. Milwaukee County is approximately 10 miles wide and about 40 miles long, with an area of 400 square miles, situated along the west shore of Lake Michigan. In this area live 840,000 people, or about an average density of 2,200 people to the square mile. This density varies naturally from about 1,000 to 7,000 per square mile, depending on the location.

If an atomic bomb falls, we can expect that 75,000 people will be killed and 75,000 will become casualties of varying severity. Of the casualties, 15 per cent or less will suffer from radiological burns, 40 per cent from traumatic injury, 50 per cent from thermal burns, and 25 per cent from shock.

In Milwaukee County we have hospitals with a total bed capacity of 4,000. This capacity can be augmented to approximately 20,000. Sources of medical supplies include that in the wholesale, retail outlets, that to be made by volunteer help, and that to be provided by the government. Medical personnel available include 1,250 doctors, 685 dentists, 4,000 nurses, 375 pharmacists, and unlimited numbers of corpsmen and first-aid personnel.

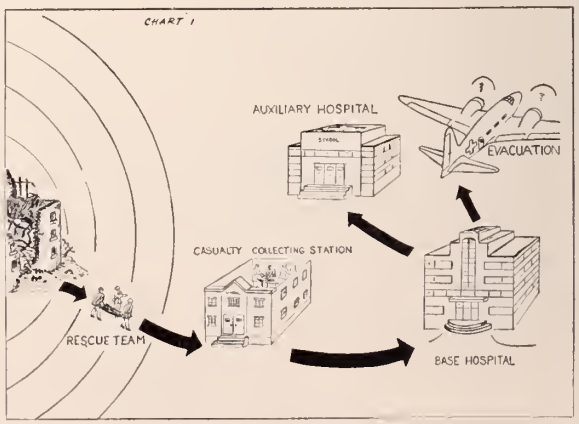
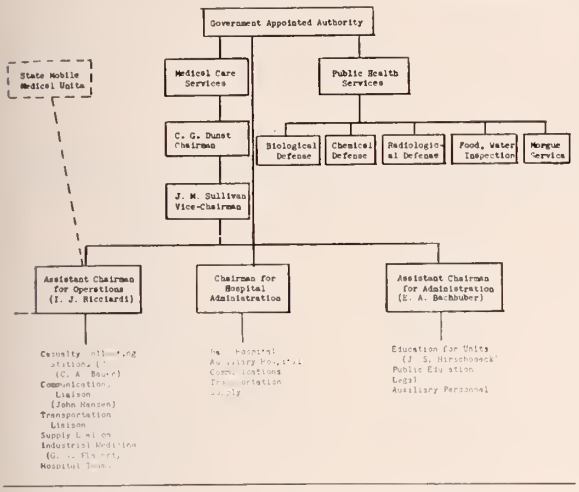


CHART 1.—*Pictorial flow chart of disaster casualties.*

CHART 2.—*Medical care services organization for Milwaukee's civil defense.*



In addition, we have medical technicians, pharmaceutical agents, laboratory technicians, and medical assistants. Additional personnel will be provided by mobile teams that will be moved into the area, when necessary, from surrounding counties, cities, and states. With these resources in personnel and material, it was necessary for the committee to organize their use so that a minimum of treatment could be given to all casualties in the first 24 hours.

In planning for the most effective use of material and personnel, the committee called upon the Society and other interested groups and individuals for advice in building an operational and administrative scheme which would have a reasonable chance to work in an emergency.

It was thought that the first zone of operation would be the casualty station. The casualty (first-aid) station has three classifications, a fixed installation, mobile installation, and a fixed-mobile installation. In Milwaukee, it is planned to use the fixed-mobile type of setup, that is, a team of 11 doctors and allied personnel, well organized into individual groups capable of changing their site of activity at will.

At present it is thought that school buildings (or similar structures) will serve as casualty stations. For organizational purposes, each casualty station will be captained by a physician with a good military and triage background, capable of welding his unit into a reasonably efficient aid station. For training and stockpiling, these buildings will be placed at the perimeter of the county. Each unit will be prepared to move the casualty station as close as practical to the source of casualties, allowing sufficient room between it and the outer perimeter of destruction to allow easy ingress and egress of emergency vehicles. At present it is planned to have 25 such mobile teams stationed about the perimeter of Milwaukee County.

In addition to specific medical personnel, it will be necessary to provide organized clerical personnel for aid in identification and classification of all casualties. Such duties will be under the direction of a trained business manager. Among other responsibilities, he will be required to forward information obtained to a central bureau of information, which in turn will help to relieve stress and panic by giving information to those who are interested in the welfare of their loved ones.

In the casualty station, or close to it, it will be necessary to provide two-way radio communication, such as a police squad car, so that each station can remain in close contact with the central control point.

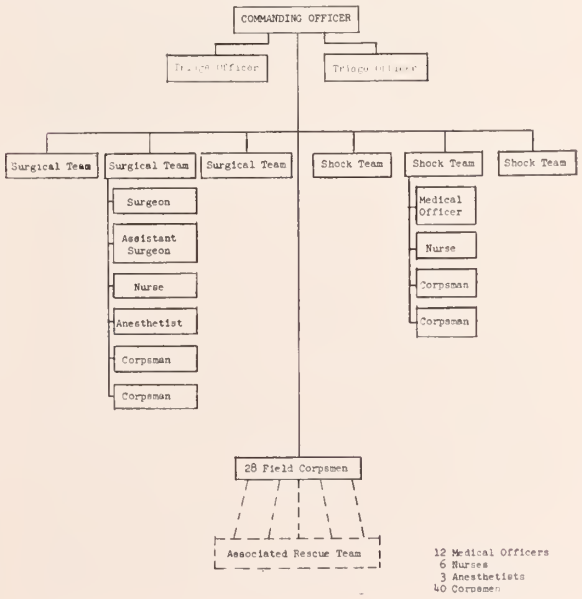
Transportation between the casualty station and the base and auxiliary hospitals must be planned and arranged so that the movement of casualties and supplies can be most efficiently handled.

The supplies of food, water, heat, and light must be arranged for by other civil defense divisions. The matter of relief for personnel in casualty stations can be facilitated through the use of mobile battalions from other parts of the state. Casualty stations must be prepared to handle decontamination for exposure to both radioactivity and gas.

Doctors have been assigned to casualty stations in Milwaukee county. It is hoped that soon the definite boundary lines of each casualty station will be established and training will begin.

After a disaster, the doctor will be expected to make a reasonable attempt to reach the casualty station to which he is assigned. If this is difficult or impossible, he will report to the nearest facility and assist in his usual capacity. Notification to the central control point, casualty station division, should be made of his presence there.

CHART 3.—*Medical organization for a casualty collecting station.*



The injured will be fed to the casualty stations by litter or other means of transportation from the damaged area. Organized teams of corpsmen will be attached to each casualty station and will operate with the mobile rescue battalions to give first-aid to casualties in the damaged area. Corpsmen may be first-aiders with additional training, men who have had medical training in the services, or someone of the allied groups of semi-medical personnel. It is hoped that medical and dental students may be assigned to these units, particularly as minor triage officers and leaders.

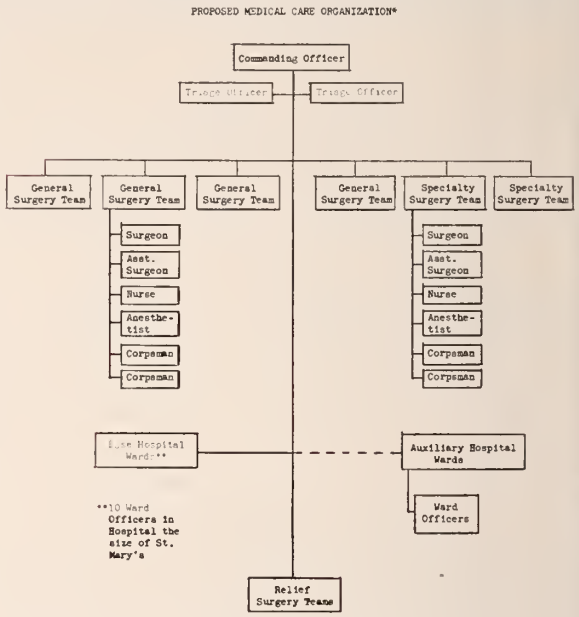
In addition to the casualty stations, it is hoped to develop first-aid stations in churches or similar installations not being used for other more important purposes. Their field of activity will be limited to care of the mobile type of casualty, requiring only minor treatment. This field of activity will have to be sharply defined, and in no way should interfere with the normal flow of casualties to the casualty station. Where practical, first-aid stations might be confined to Welfare Services Centers. First-aid units in these centers would be manned by personnel trained in advanced first-aid.

The establishment of hospital facilities, auxiliary hospitals, evacuation hospitals, and other installations is under the direction of the Milwaukee Hospital Council under the chairmanship of Mr. William Coffey. Arrangements are being made to convert many additional buildings to hospital use, as it is understood that at least half of the existing hospitals would be damaged or destroyed if a bomb dropped anywhere near the center of the city. Hospital units have been asked through the chief of staff, and a surgeon selected by him, to provide lists of doctors they wish to have in their particular institution. A pre-designated number of physicians has been allotted to each hospital.

It has been pointed out by the committee that only physicians below a certain age bracket should be used in base hospitals (which are the existing hospitals), because of the unusual demands a disaster would make upon the stamina of such individuals. Physicians not used in the base hospitals would be assigned to auxiliary and evacuation hospitals.

The committee has stressed repeatedly that there is no caste or favoritism shown in the assignment of physicians and others to their respective duty stations. Only the question of what is best for all is of concern. It should be understood that if a disaster of an atomic proportion should occur, we would all be desperately concerned with the survival of ourselves, our families, or friends, and our nation, and in such a situation all men regardless of color, race, or creed are equal. With the assignment of doctors to hospitals, it is planned to organize surgical teams, shock teams, and burn teams. The number of teams depends on the number of operating rooms in the respective hospitals. In addition, ward officers would be assigned on the basis of the number of beds in a given hospital.

CHART 4.—*Medical organization for a base hospital.*



Each existing hospital would be augmented by the use of suitable neighboring buildings. These, with the existing hospitals, would make up the base hospital. In addition, auxiliary hospitals will be developed to house casualties after definitive treatment has been provided. Evacuation hospitals will be developed and utilized to house the patients that have been in an existing hospital, but must be moved to provide room for incoming casualties.

To provide for a harmonious operation of all segments of medical civil defense, it will be necessary to provide instructors in standard procedures such as were developed by the Committee on Standard Procedures and Techniques of the State Medical Society. This program will be under the general direction of Dr. John Hirschboeck, Dean of the Marquette University School of Medicine, and the immediate direction of Dr. James Sullivan.

Recently, through the splendid cooperation of the Woman's Auxiliary to the Medical Society of Milwaukee County, the Medical Society of Milwaukee County office, and the medical branch of the Milwaukee Civil Defense organization, practically all the doctors in Milwaukee county have been registered for civil defense. An ordinance requires that all participants in civil defense must sign a loyalty oath, which is a statement that they do not belong to any subversive organization, and have a thumb print and photograph made, for a plastic enclosed identification card. The doctor will keep this card on his person to allow easy movement through the lines at the time of a disaster.

With the cooperation of all people concerned in this operation of medical emergency services, the metropolitan area of Milwaukee can be assured of minimal care in the event that disaster strikes.

Emergency Treatment of Disaster Casualties

By SUBCOMMITTEE FOR STANDARD THERAPY OF COMMITTEE ON CIVIL DEFENSE

E. A. BACHHUBER, M. D., Chairman
Milwaukee

A. A. Schaefer, M. D.,* E. R. Krumbiegel, M. D., G. F. Meisinger, M. D., Milwaukee; E. C. Albright, M. D., K. E. Lemmer, M. D., J. W. Brown, M. D., A. J. Boner, M. D., Madison; M. F. Huth, M. D., Baraboo, and E. P. Ludwig, M. D., Wausau

AT THE request of the Director of Health Services, State of Wisconsin Civil Defense, the Subcommittee for Standard Therapy of the Advisory Committee on Medical Services for Civil Defense has prepared the following outline of emergency treatment for burns, shock, fractures, extensive wounds, radiation sickness, and neuropsychiatric casualties.**

The major purpose of the outline is to standardize treatment and to act as a guide for the training of medical aid personnel. In its preparation emphasis has been placed upon the practical needs of a disaster situation in terms of providing simple emergency treatment to a maximum number of casualties with a minimum of supplies and equipment. It is recognized that frequent revisions may be necessary as new drugs, blood substitutes, methods, and procedures are developed and proved effective.

General

A. Introduction.

The successful emergency care of the 40,000 to 50,000 persons injured after atomic bomb attack demands a series of uniform minimum treatment procedures. In the medical aid stations close to the disaster area, speed will be essential; yet it is vital that such therapy as will sustain life and prevent serious deterioration in the clinical status of each patient be utilized.

The large number of injured suddenly thrown against the medical resources of the State will require that as many treatment procedures as possible be performed by medical assistants. The emergency treatment outlined in the following sections include procedures applicable not only by such trained assistants, but by the patient himself, or his neighbor.

Physicians and medical aides coming from all areas of the State should be prepared to perform a uniform type of treatment for survivors in any bombed area. Stockpiling of supplies and training courses for personnel can then be established on a uniform basis in Wisconsin.

Although the discussion of emergency treatment is organized under headings based on the nature of the lesion, it must be kept in mind that many patients will present several types of simultaneous injury. In fact, such multiple lesions may be the rule among the more seriously injured. It is important, therefore, to consider these therapeutic procedures as a whole and to *recognize the great need for a rapid medical evaluation and sorting of patients prior to the initiation of definitive treatment.*

The seriously injured must receive priority in treatment during the early hours after attack until personnel and supplies, sufficient to deal with the total problem, become available.

B. General treatment recommendations.

1. *Sorting*—A physician must be aware that the majority of those demanding treatment will have sustained only trivial wounds. His initial obligation, therefore, will be to sort casualties into appropriate categories. For this purpose the principal of *triage* (designation of *slightly, seriously,* and *mortally* wounded) is involved. Here there is no substitute for experience and common sense. The most important single advantage involved in sorting and tagging of casualties lies in the fact that it frees professional personnel all along the line for the care of the wounded for whom emergency treatment may be life saving.

2. *Covering*—Since exposure is undesirable for the *seriously* injured, all such patients should be placed upon one blanket and covered by another.

3. *Tagging*—Each patient shall have affixed an identification tag upon which shall be recorded the type and time for each treatment given.

4. *Moving*—In transportation, the unconscious patient should be rolled on the stretcher in the prone position. If conscious, he should be placed on the stretcher in the supine position if this position is not contraindicated by the nature of the injury. Dentures should be removed from all unconscious patients prior to transportation.

Emergency Treatment of Burns

Burns are expected in two-thirds of those persons who have sustained *serious* injury after atomic

*Deceased.

**In preparation of portions of this emergency treatment outline, use has been made of material presented in a similar outline written under the supervision of the committee on medical preparedness of the Medical Society of the State of New York.

LIBRARY OF THE
COLLEGE OF PHYSICIANS

attack. Frequently these will be associated with blast and crushing injuries, and during subsequent weeks, with radiation sickness.

Both flash burns and flame burns will occur, although no distinction need be made between them as regards treatment.

A. Immediate treatment given within area of disaster.

1. At this time, no complicated dressing is required. The lesions should be draped by freshly laundered sheets and towels which are essentially sterile.

2. Constricting clothing should be slit and shoes loosened or cut. Removal of clothes is inadvisable since exposure may precipitate shock.

3. Transportation to the nearest medical treatment station.

4. It is recommended that each family unit assemble a "home pack" consisting of the following minimum items:

a. One sheet per person (inner dressing).
b. Two average size bath towels per person for bulk.
c. Two face towels.
d. Rolls of 3 and 4 inch gauze.

It is suggested that laundries cooperate in the program by seeing that above articles are laundered in a fashion to make them practically sterile, and put up in very heavy paper or other material and specially labeled. This "home pack" could be placed in an easily accessible place and might be of use in any emergency. The "home pack," in many instances, would not require any special purchases and would contain the minimum material per person to do an adequate dressing of a severely burned patient. A package of safety pins should be clipped to the outside of the pack.

B. Later treatment given at medical aid stations.

1. Patients should be carefully examined by a physician for total injuries other than burns.

2. Morphine should be given for the relief of pain.

3. There should be no preparation of the burned surface other than removal of loose clothing and gross contamination such as clumps of dirt. No débridement should be attempted, nor should there be any application of sprays, triple dye, tannic acid, or medicated ointments. No blisters or blebs should be opened, and no home remedies such as butter and lard applied. The burned surface itself should be essentially untouched.

4. Fine mesh gauze should be applied directly to the burned area. No ointments such as petroleum jelly or boric acid strips are necessary. For self help, if fine mesh gauze is not available, strips of sterile sheets or clean freshly-laundered sheets may be applied as the first layer of dressing. This layer should be applied in a longitudinal direction.

5. Circular constricting dressings should be avoided. Bulk, preferably of an absorbent material, in any clean available form, should be applied over the basic layer to produce moderate pressure. The bulk can be applied to the patient with roller bandages or strips of any kind of material, although tight constriction should be avoided.

6. *For shock,* treatment with intravenous fluid such as plasma, serum albumin, blood, and saline and glucose should be given. Oral fluid such as a salt solution made by dissolving 3 to 4 Gm. of sodium chloride and 2 to 3 Gm. of sodium citrate or baking soda per liter of water should be utilized.

7. Penicillin, aureomycin, or terramycin should be given by either parenteral, or oral administration, depending on the patient's condition, to control infection.

8. Tetanus toxoid or antitoxin should be given, using usual precautions before administering the latter.

9. It is recognized that some revision of emergency dressing may be necessary after the casualty has been hospitalized. Fine mesh gauze or vaseline gauze pressure dressings may be applied at the discretion of the physician and depending upon available supplies.

10. In the event of an overwhelming number of casualties, it may be necessary to employ the "open method" of burn therapy. General care of the patient would be as described, but initial preparation of the burn area would be more extensive than with the "closed method." Patients require considerable nursing care during the "drying out" period, and transportation of patients so treated presents great difficulties. Partial thickness burns of not over 30 per cent of body surface involving one side of the body, and burns of head and buttocks are best adapted to the exposure treatment.

Shock and Crushing Injuries

The atomic blast will cause extensive damage to structures, which in turn will make crushing injuries a common condition among the casualties. Patients extracted from beneath debris or caught between buildings are illustrative of crush injuries. Under the stress of the situation, such patients may insist on walking about or assisting in rescue work. Particular care should be taken to note on the tag that such patients have sustained a crush injury so that continued observation and necessary treatment may be carried out.

A. Immediate treatment given within area of disaster.

1. Hemorrhage should be arrested immediately.

2. Fractures should be immobilized on the spot before moving the patient.

3. All shock patients should be transported in the prone position.

B. Later treatment to be given at medical aid stations.

1. First stage.
   a. On arrival at the medical post, all shock patients should be placed in the Trendelenburg position.

b. Whole blood, type O, or plasma should be given intravenously in that order of preference.
c. Hypotonic saline and other oral fluids should be given as the patient's condition permits.
d. Morphine sulphate, 1/6 to 1/4 grain, should be given, preferably intravenously.
e. The patient should be kept warm with blankets. No other heat should be applied.

2. Later stage—if patient cannot be promptly sent to a hospital for definitive treatment.

a. Repeat morphine injection should be given no earlier than two hours after the first dose, and only if extreme pain is present. Because of poor absorption, over-dosage of morphine is very easy in the patient suffering from shock.
b. Barbiturates in moderate doses may be used to allay panic or hysteria.
c. The Trendelenburg position should be maintained.
d. A good airway must be maintained—by means of a tracheotomy if necessary.
e. Vomiting may be treated by turning patients on their faces, and naso-gastric tubes, if available, may be inserted for drainage and/or suction.
f. Fluid therapy should be continued in the following order of preference: (1) whole blood, type O, (2) plasma or serum albumin, (3) saline and glucose. No potassium-containing fluids are to be given in cases of shock or crushing injuries. Careful follow-up of urinary output is recommended.
g. Careful records of all treatments should be noted on the patient's medical tag.

The Treatment of Extensive Open Wounds

Extensive open wounds are expected to make up a large proportion of the injured. Simple treatment of the lesion itself will be the rule during the early period after attack. Emphasis must rather be placed on the prevention of shock and infection until the patient can be transported to the emergency hospital for definitive treatment.

A. Priorities in treatment should be considered in the following order: massive hemorrhage, chest wounds, abdominal wounds, crush injuries, and head and spine injuries.

B. Immediate treatment within the area of disaster should be, above all, simple and should aim only to preserve life, prevent shock or treat that condition if already present, and prevent further contamination of an already contaminated wound. Tetanus toxoid or antitoxin should be employed freely. Combined serum (gas gangrene with tetanus antitoxin) should be used when devitalized tissue is present and penicillin or available antibiotic should be given routinely. Measures directed at the wound per se should be:

1. Application of a sterile dressing to cover the wound completely. If a sterile dressing is not available, clean cloth such as a pillow case or towel should be utilized.
2. Except in the event of a traumatic amputation in which there is exsanguinating hemorrhage, the use of tourniquets should be discouraged. Wherever possible, hemorrhage should be controlled by massive pressure dressings.
3. No attempt should be made to remove foreign bodies or gross contamination. The probing of wounds, irrigation with any material, or installation of so-called antiseptic solution is condemned.

C. Suggestions as to treatment of specific types of wounds or injuries.

1. Wounds of the extremities.
   a. Hemorrhage from large vessels must be controlled immediately. If pressure is unsuccessful, clamping and ligature should be done if facilities are available. Tourniquets should be employed guardedly if other measures fail or are not available.
   b. After hemorrhage is controlled, massive occlusive dressing should be applied.
   c. The extremity should be kept splinted and condition should be observed frequently until definitive treatment can be carried out.
2. Chest injuries.
   a. An open sucking wound of the chest should be occluded immediately by a massive pressure dressing.
   b. In order to splint the affected side of the chest and insure maximum respiratory exchange, the patient with a chest injury should be placed with the affected side down.
   c. An unstable chest secondary to multiple rib fractures should be stabilized immediately with a circumferential binder of material at hand to prevent paradoxical respiration.
   d. Evidence of a pneumothorax compressing the lung and mediastinum should be treated by immediate aspiration in the second or third interspace anteriorly. If air recurs under tension, a flutter valve should be devised or a catheter leading to a water seal should be placed in the chest.
   e. A massive hemothorax causing respiratory distress should be aspirated upon diagnosis. Continuing or recurrent intrathoracic hemorrhage demands rapid transfer of the patient to a hospital where exploratory thoracotomy can be carried out.
   f. An adequate airway must be maintained.
   g. Demerol is preferred for the relief of pain.
   h. If available, oxygen should be administered.
3. Abdominal wounds.
   a. Abdominal injuries should be treated by the simple application of a massive sterile dressing.

b. No attempt should be made at wound manipulation or the replacement of viscera.
c. Patient should be placed flat on his back.
d. Fluids and food should be withheld.
e. Parenteral aureomycin or similar antibiotic should be administered if available.

4. Brain or spinal injuries.

a. A patient in whom an intracranial or a spinal cord injury is suspected should be carefully rolled on a stretcher so that he rests in a face-down position, but this position should not be used in patients in whom injury to the cervical spine is suspected.
b. A padding 3 to 5 inches thick is to be placed under the lower chest to relieve pressure and to facilitate respiration.
c. Adequate airway must be maintained especially in unconscious patients. The face should be turned to the side to prevent aspiration of vomitus or blood.
d. Morphine should be avoided except in cases of extreme restlessness. Codeine or demerol might be effective.
e. Patients with a cervical spine fracture should be placed face up, possibly with mild hyperextension of the neck. Extreme caution must be used to prevent any flexion of the head and any manipulation would be criminal.

Emergency Treatment of Fractures

Fractures are expected to make up a significant proportion of injuries due to direct blast, falling structures, and flying debris. Obviously, the first treatment must be quite hurried and quite simple. Because of expediency and need for simplicity, only the simplest supplies and materials must be used. As the injured are transported to the periphery, attempts at better and more accurate immobilization of the fractures should be undertaken by the physicians available. Definitive treatment, as a rule, will be performed by the surgeons at the remote hospitals and installations.

A. Immediate treatment given within the area of disaster.

1. Stretcher bearers should be instructed that in gathering patients, the following should be observed:

a. The patient should be immobilized on the stretcher during transportation.
b. If the injury or fracture involves the upper extremity and the patient is ambulatory, the injured part should be immobilized against the patient's body.

2. Simple materials may be utilized to provide immobilization. Ordinary sticks, boards, rolled newspapers or magazines, or the stretcher pole itself may be used. Both legs may be tied together. Pieces of clothing may be used to bind the upper extremity to the body.

B. Later treatment given at primary medical aid posts and clearing stations.

1. Morphine may be given for pain. Previous experience with war casualties has taught that dosage should not be in excess of $\frac{1}{6}$ to $\frac{1}{4}$ grain. Casualties in shock or impending shock do not tolerate large doses well.

2. The patient should be in the shock position. (Reclining with feet elevated).

3. Plasma, whole blood, or substitutes may be given as indicated.

4. Closed fractures.

a. Skull fractures should be evacuated for definitive treatment, transportation being done with the patient in the prone position, with the face turned to the side to prevent aspiration of vomitus or blood.
b. Fractures of the shoulder, arm, and elbow should be immobilized by means of sling and body bandage. Fractures of the forearm, wrist or hand should have a light wood or newspaper splint applied before transportation.
c. Lower extremity fractures should be treated by Thomas splint and traction. If such splint is not available, wooden splints or tying the legs together will suffice. For a foot fracture, a light wood splint or newspaper should be used to prevent pressure from blankets on the toes.
d. For fractures of the cervical spine, the patient should be laid face up on a board or flat surface. For fractures of the dorsal and lumbar spine, the patient should be placed prone on a flat surface, with head turned to one side.

5. Open fractures.

a. If the bone protrudes through the skin and is pulled in by traction, note of this fact should be made on the patient's tag.
b. An open wound or protruding bone should be covered with a dry sterile dressing.
c. Antibiotics should be administered if available.
d. The remainder of the treatment is as listed for closed fractures.

Treatment of Radiation Casualties

A. *General*—It must be recognized that need for therapy of radiation casualties will largely occur *later* than the initial 72 hour period after atomic attack. These casualties will constitute probably 20 to 30 per cent of the total and will require minimal emergency medical attention.

B. Recognition of Radiation Casualties.

1. By location in relation to ground zero (inadequate or no shielding)

a. Group A: under half mile (about 1,000 yards) exposed persons will receive a lethal dose (600 r and up).
b. Group B: from ½ to 1 mile (about 0.8 mile or 1,400 yards) exposed persons will receive an LD–50 dose (400 r), i.e., about 50 per cent will die.
c. Group C: from 1 to 1½ miles exposed persons will receive sublethal dose (300 r and below).
d. Over 1½ miles radiation casualties are very unlikely.
NOTE: Shielding should be considered in classifying patients.

2. By character of symptoms.
a. Nausea and vomiting on day of bombing occurs in all three groups. The earlier and more severe the vomiting, usually in 1 to 2 hours, the more likely it is to be a Group A (lethal) casualty.
b. Diarrhea and fever in the first two days is strong evidence for Group A (lethal) casualty.
c. Those patients in Group A will probably not live long enough to develop further specific radiation symptoms. Symptoms other than nausea and vomiting will not appear in Group B and C probably before the end of the first week, so are not strictly of concern in the emergency handling of radiation casualties.

C. Treatment of Radiation Casualties.

1. Attempted classification on basis of above into the non-salvable (Group A) and salvable (Group B and C) cases.

2. Tag cases as to location in relation to ground zero at time of blast, and shielding, and presence of symptoms.

3. Bed rest as soon as possible for all three groups.

4. For Group A casualties: no evacuation to definitive treatment center. Palliative and supportive care only.

5. For Group B and C casualties (salvable): evacuation to definitive treatment center.

The foregoing applies to external radiation. Internal irradiation due to fission products, etc. is believed to be statistically insignificant.

Psychiatric Casualties from Atomic Attack

A. General Considerations.

The psychologic aspects and psychiatric problems of an atomic disaster will be significantly influenced by the manner in which a community prepares itself to cope with such a catastrophe. In few other circumstances will so much depend upon strong civic leadership, meticulous planning, adequate training, and efficient and well co-ordinated execution. Much can be accomplished by the thorough dissemination of authoritative information concerning the practical aspects of an atomic bomb disaster. Past experience has shown that many psychiatric casualties can be prevented if the civilian population is properly informed and prepared. To accomplish this, it is imperative that a State-wide educational program, devised to deal with the civilian aspects of atomic and biologic warfare, be instituted at the earliest opportunity. Furthermore, every community plan must include appropriate training drills in order to better acquaint individuals with their specific and general responsibilities. This is especially important in regard to schools, hospitals, industries, and buildings in which large groups of people are gathered.

In spite of the various prophylactic measures which will be undertaken, numerous psychiatric casualties will occur. It is estimated that approximately 10 per cent of the population of a bombed community will be affected in varying degrees of severity. One-third to one-half of these will require treatment in medical aid centers or hospitals. Every effort must be made to minimize panic and mass hysteria. The rapid establishment of order within the disaster area, efficient traffic control, the prompt establishment of routes of casualty evacuation, the efficient direction of thousands of dazed and bewildered people, and the prompt establishment of easily accessible information stations become critically important considerations in this regard.

B. Emergency Treatment.

1. *Evacuation*—Casualties should be given necessary medical care and moved to a quiet area where they can receive adequate supervision as rapidly as possible. With proper organization, many can be constructively occupied in various types of work. Others of the less serious casualties can, with assistance, be directed to relatives and friends. When available, advantage should be taken of facilities allowing for care of casualties who can be stabilized in two or three days so that hospitalization of them can be avoided. (Much in the same manner as emotional disturbances were handled in the combat areas in World War II.)

Severe psychoneurotic casualties should be evacuated to previously designated hospitals. Preferably, they should be moved in groups and accompanied by an attendant.

Psychotic casualties should be evacuated to state and county psychiatric hospitals.

It is recommended that special teams be organized for the care of psychiatric casualties so that the care of critically injured and burned casualties will not be jeopardized.

2. *Sedation*—Sodium Amytal is the drug of choice. This should be given by mouth, whenever possible, in doses sufficient to produce relaxation or sleep, whichever is indicated. Intramuscular or intravenous administration will be necessary in some instances.

Sodium Amytal should not be given in the presence of shock.

Hospital Treatment of Disaster Casualties

By COMMITTEE ON CIVIL DEFENSE

M. J. MUSSER, M. D., Chairman *
Madison

E. P. Ludwig, M. D., Wausau; K. E. Lemmer, M. D., Madison; J. S. Wier, M. D., Fond du Lac, and E. A. Bachhuber, M. D., Milwaukee

THE hospital treatment of disaster casualties is an outline of methods of definitive treatment to be used following the emergency treatment of atomic casualties which was carried out by the first-aid teams. Because of the over-whelming numbers of expected casualties, certain types of well accepted but time consuming methods of therapy must be abandoned in favor of briefer methods.

The types of injuries are difficult to estimate and will vary considerably depending upon factors which are difficult to calculate in advance. Many of the patients will have injuries of multiple types, so that the total number of injuries will exceed the total number of patients. Based on an atomic air burst of the Hiroshima type and strength, over a population density of 13,000 population per square mile, it is estimated that each 100 patients might have injuries of the type and percentages illustrated by table 1.

TABLE 1

Types of Injuries by Per Cent	*Types of Injuries per 100 Patients*
Burns, 70%	
Third degree burns, 33%	23
First and second degree burns, 66%	47
Mechanical Injuries, 70%	
Fractures, 12%	8
Lacerations, 38%	27
Contusions, 50%	35
Radiation Illness, 15 to 30%	15
Total injuries	155

It is recognized that there are some differences of opinion as to the various types of treatment and that many hospitals may want to carry out plans of treatment of their own making. The following suggestions have been compiled by a committee and may be used as desired.

Hospital Treatment of Fractures

In the event of an atomic attack about 10 to 12 per cent of the injured will have fractures. Of these, approximately 50 to 60 per cent will be compound; and 12 per cent will be multiple (fractures of more than one extremity). The management of these cases will in no way depart from the usual civilian procedures except as the fractures are complicated by various types of wounds, craniocerebral injuries, burns, and radiation sickness.

Treatment of Shock

Every effort will be made to adequately treat casualties in shock in the aid stations. However, in many instances the shock state will return during evacuation. Other casualties, not in shock at the time of evacuation, will be in shock by the time they arrive at the hospital. Consequently, the treatment of shock will be a major therapeutic procedure in the hospitals.

Shock should be anticipated in the presence of major blood loss, extensive soft tissue injuries, deep or extensive burns, major fractures, intracranial injuries, intestinal obstruction, perforation of a viscus, and acute, severe sepsis. Determination of the cause of shock must be accomplished as soon as possible and appropriate therapeutic measures instituted so that the effectiveness of the treatment of shock will not be dissipated.

In the presence of shock, whole blood, type O, should be used in sufficient quantities to restore an adequate circulating volume. This may mean 1,500 to 2,000 cc. in certain cases. Anesthesia and surgery should be avoided, if possible, until shock is corrected, except in those cases of active hemorrhage of internal origin. If blood is not available, plasma, albumin, dextran, hydrolyzed gelatin, Periston, and perhaps okra should be used in that order. Saline and glucose solutions are of only temporary benefit and should be used only when other materials are not available.

Oxygen therapy, unless used in conjunction with blood, is of little value as the patient's circulating blood is usually saturated. In shock, it is the transport mechanism which is at fault.

The head down position should be used except in cases of respiratory embarrassment in which a semi-sitting position is recommended.

All pressor drugs are of little benefit, for while they may temporarily raise the blood pressure, they do not increase the cardiac output or increase the capillary flow.

Conserving body heat by the use of blankets is desirable, but adding heat by means of heating pads and hot water bottles may be harmful since it produces a deviation of the blood to the periphery.

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High environmental temperatures are also deleterious.

Oral fluids, including saline solution, made by adding 3 to 4 Gm. of sodium chloride to a liter of water, and sodium bicarbonate–saline solution made by adding 2 to 3 Gm. of sodium bicarbonate in addition to the sodium chloride to the liter of water, can be given as tolerated. It is useless to force these solutions until a normal circulation is reestablished and the absorptive capacity of the gastrointestinal tract is regained.

Intravenous morphine in doses of 10 to 16 mg. ($\frac{1}{6}$ to $\frac{1}{4}$ grain) should be given for pain when shock is present. Otherwise, the morphine can be given subcutaneously.

If after following the afore prescribed treatment the shock condition does not respond, it is probably due to:

(1) concealed hemorrhage, (2) irreversable shock, or (3) shock due to some condition other than blood loss. In such cases it is useless to administer more blood as pulmonary edema may result.

Crushing Injuries

A shock-like picture of the crush syndrome does not appear ordinarily until some time after release of the crushed portion of the body. There is undoubtedly some toxic factor released with the subsequent renal damage and anuria. This may be myohemoglobin from the crushed muscle fibers. Treatment of the crush syndrome is directed to two major considerations: (1) prevention of edema, and (2) prevention of renal damage.

Compression bandages should be applied immediately after the victim is extricated from the debris and should be left in place after arriving at the hospital unless there is evidence of wounds or fractures requiring early care. The extremities should be kept cool but not cold. Papaverin, Priscoline, and paravertebral block with Novocain are indicated to eliminate vaso-constriction. Alkalies by mouth, 30 to 40 Gm. of sodium citrate and sodium bicarbonate are to be given to maintain an alkaline urine, thereby holding the myohemoglobin in solution and preventing its precipitation in the kidney tubules. Amputation may be imperative if the trauma is severe enough. An occasional case of tourniquet shock can be expected in this type of emergency. This is to be treated similarly to the crush syndrome. Additional treatment should be directed toward the prevention of shock, replacement of blood loss, and provision of a daily fluid intake sufficient to maintain a urinary output of 1,000 cc. per day. Antibiotics to combat infection, tetanus antitoxin or toxoid, and polyvalent gas gangrene antitoxin should be given.

Treatment of Burns

If shock is present the shock should be treated with blood and plasma before any attempt is made to treat the burns. The fluids should be administered in a ratio of two units of plasma to one of blood.

If emergency burn pads are satisfactory, and held in place covering the burned areas, they need not be disturbed for five to seven days. If the dressings are not satisfactory, they should be removed after the shock has been treated and fine mesh gauze should be applied to the burned areas. Pressure then should be applied with mechanics waste, cotton, or Kerlex gauze, wrapped with stockinette or elastic bandages. It is unlikely that sufficient vaseline gauze will be available for the expected number of burn cases. It should be remembered that in cases of burned extremities, the fingers and toes should be included in the pressure dressing, even though they are not burned. No attempt should be made to open the blisters but only loose skin, dirt, and pieces of clothing removed. It is also doubtful whether the burned areas can be properly cleansed, but if possible a bland soap or detergent should be used.

In most instances burns can be dressed without anesthesia by the use of narcotics and sedatives. General anesthesia is not recommended. The dressings need not be changed for from five to seven days unless a febrile response indicates infection under the dressing. Penicillin, 300,000 units aqueous, crystalline G, should be given intramuscularly every 12 hours.

Tetanus toxoid or antitoxin should be given in prophylactic doses to all burn cases.

Fluid balance can be improved by drinking water to which 3 to 4 Gm. of salt and 2 to 3 Gm. of sodium bicarbonate per liter have been added.

The open method of burn treatment combined with ACTH and penicillin has been given an extensive trial in the Far East Command. The opinion was unanimous that the open method is distinctly inferior to the closed method with occlusive dressing.

Craniocerebral and Spinal Injuries

Because of the peculiar nature of these injuries and the specialized clinical and therapeutic measures which they require, each hospital should organize special units for their management. This is especially desirable when professional staffs include qualified personnel (neurology, neurosurgery, and orthopedics). In such instances, appropriate civil defense authorities should be notified of the existence of such units so that selected casualties can be evacuated to them. Functional planning should include facilities and equipment for the performance of a large volume of neurosurgery, expeditious x-ray examination of casualties, and numerous spinal punctures, as well as the other diagnostic and more general therapeutic measures pertaining to these types of casualties.

Most craniocerebral and spinal cord injuries will result from direct trauma. Falling buildings and flying debris will account for the largest number, and falls from a height where feet or head sustain the impact the remainder.

About 6 per cent of those admitted to hospitals may be expected to have a head wound as the major injury. Craniocerebral injury, alone or in combination with other injuries, may be responsible for as high as 40 per cent of the immediate mortality. It must be emphasized that injury to the brain rather than the scalp wound is the most important consideration in the treatment and prognosis. Penetrating wounds of the head will probably be encountered much more frequently after atomic bombing than the closed type of craniocerebral injury occurring in ordinary civilian medical practice. Likewise, penetrating injuries of the spinal cord will be more common.

Brain Injuries

Scalp wounds and skull fractures should be treated according to currently accepted methods with special attention to the prevention of infection. All craniocerebral wounds should be closed. The treatment of brain injuries resolves itself into the following:

1. *Management of initial shock*—Simple, uncomplicated head injuries rarely cause a persisting shock picture. Prolongation of shock suggests cerebral contusion and/or laceration or some associated injury.

2. *General care of the casualty*—This should include the semi-prone position to minimize the possibility of respiratory obstruction from accumulated secretions in the unconscious patient and the prompt removal by suction of these secretions when they occur.

3. *Establishment of nature of injury*—Spinal fluid examination should not be done routinely. When indicated, it is of value both in differential diagnosis and as a guide to management of the injury since the presence or absence of blood and the initial spinal fluid pressure provide invaluable information. Spinal puncture should never be done when the patient is disturbed or when there are signs of medullary disturbance. The Queckenstedt test should be omitted. Fluid must be withdrawn very slowly, and the pressure, if elevated, never reduced below normal.

4. *Control of cerebrospinal fluid pressure and cerebral edema*—Spinal fluid pressure may be helpful in establishing proper daily fluid intake. The effect of shock and dehydration upon it must be taken into consideration.

5. *Prevention of infection.*

6. *Definitive surgery*—(Evacuation of hematomata, removal of indriven bone fragments and missiles, correction of depressed skull fractures, etc.)

Spinal Cord

The most common injuries of the spinal cord will include concussion, contusion and laceration, hemorrhage, and compression by fractured vertebrae or epidural hematoma. The presence of an injury, its nature, and location can be determined in the majority of cases by the neurologic signs, x-ray findings, and spinal fluid changes (cellular and manometric). Hematorrhachis without cord or root injury is unlikely to produce symptoms other than meningismus. With concussion there is definite but fleeting evidence of injury with complete recovery. In hematomyelia, the amount of hemorrhage is usually proportional to the degree of trauma resulting in injury, varying from a mild contusion to a severe laceration. Symptoms are usually those of a fairly well localized disturbance of spinal cord function. Direct penetrating injuries will be accompanied by neurologic signs commensurate with the amount of spinal cord damage.

Compression fractures of the vertebrae occur most frequently at the level of dorsal 12 or lumbar 1, where a relatively mobile meets a fixed portion of the spine, with acute flexion as the usual mechanism of injury. Dislocations without fracture are found most frequently in the cervical region. Aside from the orthopedic consideration, vertebral injuries are important in regard to the spinal cord damage they have produced by contusion or compression, or might produce if improperly treated. In general, if after injury, complete motor and sensory loss is present below the level of the lesion, the cord has been hopelessly damaged. If some degree of sensation and movement remains, part of the loss of function may be due to hemorrhage and edema in the cord substance. When this edema subsides and hemorrhage is absorbed, considerable return of function may occur.

Treatment should consist of the following:

1. *Proper handling to prevent further injury*—Movement of the casualty must be supervised by properly trained personnel. A firm stretcher should be used, and flexion, or extension of the spine must be avoided.

2. *Treatment of initial shock*—Influence of hypoxia resulting from disturbance of respiratory mechanics due to cervical cord injuries must be considered.

3. *Establishment of nature of injury*—Spinal puncture with Queckenstedt and manometric studies should always be done.

4. *Definitive orthopedic or neurosurgical measures*—Laminectomy is indicated as follows:

   a. If initial paralysis is incomplete but gradually progresses.
   b. When a block is present (as indicated by manometric studies). *Exception*—fracture-dislocation or dislocation which can be reduced by traction and/or hypertension.
   c. When x-ray findings suggest impingement upon the cord by bony fragments.
   d. In most instances of direct penetrating injuries.

The time element is of utmost importance. In the presence of spinal cord compression, unless exist-

ing pressure is relieved within 18 hours, the damage will be permanent.

Treatment of Wounds

Extensive lacerated wounds from flying debris will be the type most frequently encountered. Certain basic principles govern the treatment of all wounds, but it must be emphasized that the treatment of each wound must be individualized to meet the problem as it exists. The simplest procedures must obviously prevail because of the large number of casualties. Perhaps it will be possible in a few instances to close the wound with the hope of primary healing. Even under ideal conditions when extensive wounds are closed, it cannot be predicted with certainty that such a wound will not become the site of a fulminating infection which will endanger the life of the patient. In an atomic disaster, the element of time, and other conditions such as the poor condition of the patient, extreme contamination, extensive loss of substance, and damage to blood supply will contraindicate closure after débridement.

No attempt will be made to close extensive wounds in the aid stations prior to evacuation of the casualty to a hospital. Six hours is arbitrarily taken as the time interval after which wounds are closed with hesitancy. Regardless of circumstances, any wound 10 hours old under disaster conditions will be considered as infected. It is likely that the majority of casualties will not reach hospitals before six to ten hours have elapsed.

The use of penicillin should be routine in punctured wounds and extensive lacerations. Tetanus antitoxin or toxoid should be given in prophylactic doses for all open wounds. Gas bacillus antitoxin should be reserved for those cases in which a need for it is clearly indicated.

Abdominal Injuries

About 5 per cent of those wounded who survive will probably have abdominal injuries. Of this group, 15 per cent will have no penetration of the peritoneal cavity. Three-fourths will have accompanying injuries, such as compound fractures and traumatic amputations. When to operate is a critical decision. In no type of injury will problems be more complex and mature surgical judgment more necessary. If the condition of the patient does not respond rapidly to blood and plasma in the absence of other severe injuries, operative procedures must be undertaken for continuing hemorrhage or an established peritonitis.

Principles underlying the care of patients with injuries to the abdomen are as follows:

1. Exploratory laparotomy on suspicion of visceral injury.

2. Thorough exploration.

3. Intact peritoneum beneath penetrating wound of abdominal wall tends to eliminate visceral injury.

4. Penetration of the peritoneum necessitates inspection of the entire mobile intestine, mesentery, and omentum and the fixed organs in the region of the wound.

5. All structures must be proved intact when abdominal trauma was caused by a blunt object or crushing.

6. Absence of blood, intestinal content, or inflammatory exudate upon opening the peritoneal cavity does not signify freedom from visceral injury.

The immediate reaction of the patient, both systemic and local, may not be indicative of injury. The importance of keeping the patient under observation for delayed signs and symptoms cannot be stressed too strongly.

Types of injuries:

1. Contusions to the abdominal wall may present a very perplexing problem for there is no sign or combination of signs sufficiently constant to indicate whether or not visceral injury is a part of the picture. Keeping the patient under observation and repeated examinations are advised. A rupture of the rectus abdominus muscle and deep epigastric vessels leading to a hematoma of the abdominal wall may be confused with deeper injury.

2. Small bowel perforation is usually manifested by the signs of peritonitis and ileus with or without the presence of free air in the abdominal cavity. This requires immediate surgery with repair or resection as indicated. Exteriorization of small bowel and enterostomy should be avoided.

3. Large bowel perforations may give few symptoms early. Under disaster conditions, it will be inadvisable in most cases to consider closure of the bowel or anastomosis. The only exception is in the treatment of rectosigmoid injuries where mobilization cannot be effected and in which a proximal colostomy is to be done. Ordinarily the perforated segment should be mobilized to permit exteriorization through a laterally placed separate abdominal incision.

4. Wounds of the rectum should be treated by means of a proximal colostomy. Perforations should not be sutured but wide posterior drainage should be established.

5. In injuries to the spleen, splenectomy is the surgical procedure indicated.

6. Wounds of the liver, unless extremely small, will require exploration with removal of loose fragments with control of the hemorrhage either with hemostatic packs of oxycel or gelfoam or the use of hemostatic mattress sutures. Such wounds should be drained.

7. Perforation of the urinary bladder is usually associated with injuries to other viscera. Repair of the urinary bladder should be accompanied by suprapubic cystostomy in all cases.

8. In injuries to the kidney, conservative management is indicated reserving nephrectomy for fragmentation of the organ and persistent hemorrhage.

9. Hemorrhage into the mesentery or into the retroperitoneal space may be indistinguishable from perforation of the viscus. If perforation of the bowel can be excluded, no intervention is indicated unless there is continued hemorrhage.

Chest Injuries

On admission the patient should be evaluated as to general condition, shock, blood loss, and type of chest wound.

Shock should be treated in the usual manner by elevation of the foot of bed, heat, and oxygen, and minimum sedation given until shock controlled. In severe shock, from 1,000 to 1,500 cc. of blood may be necessary.

In rare instances of uncontrollable bleeding exploratory thoracotomy may be necessary concomitant with shock therapy. In the vast majority of cases, however, shock is controlled first, and definitive treatment provided later. If measures for resuscitation fail even with the administration of 1,000 to 1,500 cc. of blood within two hours, then exploratory thoracotomy is indicated, for uncontrollable bleeding is the probable cause.

Chest wounds are divided broadly into nonpenetrating and penetrating. Penetrating wounds are characterized by a sucking sound resulting from sudden passage of air into and out of the pleural cavity with each respiration. Treatment for these wounds consists of the following:

Nonpenetrating Wounds

1. Lacerations.
   a. Débridement, approximation of external chest layers by suturing.
   b. Antibiotics depending on degree of contamination.
   c. Toxoid or antitoxin depending on patient's previous preparation.
2. Rib fractures
   a. Adhesive strapping or 4 inch Ace bandage applied only to lower ribs at the end of expiration. Codeine for pain control.
   b. In multiple rib fractures, in addition to above, the daily injection paravertebrally of the involved intercostal nerves with ½ per cent Novocain or other local anesthetics will not only offer pain relief, but it will also prevent shock and pulmonary edema.

3. Chest x-ray may demonstrate a pneumothorax caused by rib fragments puncturing lung. When present, lung should be expanded as described under penetrating wounds.

Penetrating Wounds

1. Immediately apply a vaseline gauze pack and adhesive over open wound at end of expiration. Treat shock as already described.

2. When condition improves or is stable, x-rays are taken to determine extent of chest wall damage, pneumothorax, hemothorax, and lung destruction, and the patient is prepared for surgery.

3. Surgery is done under general anesthesia. Extent of repair determined by the amount of damage and availability of a trained surgeon.

4. In any event the wound should be débrided, any hemothorax controlled, and the chest wall snugly closed in layers with about a ⅜ or ½ inch rubber tube drain which is connected to a bottle placed on the floor next to the bed. The tube must be below water level at all times!! Other methods of continuous suction may be employed to expand lung to chest wall if negative pressure is maintained between −6 to −12 cm. of water.

5. Tetanus antitoxin or toxoid is given.

6. Blood given freely postoperatively when necessary.

7. Breathing exercises, consisting of deep breathing, turning from side to side, and coughing, must be done hourly to prevent atelectasis.

8. Daily x-ray, particularly in presence of rapid respiratory and pulse rates to determine possible presence of pneumothorax, hemothorax, or atelectasis.

Hospital Treatment of Psychiatric Casualties

It is neither the intention nor is it possible for general hospitals to treat acute psychiatric casualties following atomic disaster, if for no other reason than the large number of such casualties anticipated. It has already been emphasized that careful planning and preventive measures, prior to disaster, will decrease our concern in this respect. State and private mental hospitals can alleviate this situation only to a very limited degree. Therefore, certain types of buildings will necessarily have to be earmarked for such an emergency.

However, it is to be kept in mind that sufficient psychiatric bedlam will exist in all general hospitals by virtue of the associated psychiatric overlay in a large percentage of cases, in which there is severe physical trauma. For these casualties and the few uncomplicated psychotic or acute anxiety conditions which may find their way into a general hospital, certain simple measures of treatment should be instituted. If there is no contraindication, medically or surgically, the physical casualty complicated by acute psychiatric manifestations can be given 6 to 9 grains of Sodium Amytal, either by mouth, intravenously, or by rectum, in order to produce complete narcosis for 24 to 48 hours. This also applies to the uncomplicated psychiatric casualty. Paraldehyde in physiological doses, by mouth or intramuscularly, may be preferred, especially for the aged. Prolonged narcosis for several days, if necessary, is not contraindicated, if the patient is permitted to emerge sufficiently to permit the ingestion of nourishment. Hydrotherapy, in the form of wet packs or baths, is ideal, wherever possible. In such an emergency, the use of an immediate member of the family as a nursing aid, providing their movements in the hos-

pital can be restricted to the patient's bedside, would solve obvious problems and give the patient a sense of assurance and comfort.

Hospital Treatment of Radiation Syndrome

1. No intensive treatment is required for the first few days other than bed rest. Evacuation to definitive treatment centers should proceed as rapidly as possible to remove the overload from hospitals in the immediate area.

2. Bed rest. Complete.

3. Adequate nursing care. Especially with reference to oral and skin hygiene.

4. Adequate fluid intake. Especially important if diarrhea and resultant dehydration is present. Suggested forms are as follows:

   a. By mouth in form of ordinary fluids plus salt solution if vomiting is not present.

   b. If vomiting is present parenteral fluids as follows: 1,000 cc. of normal saline and 1,000 cc. of 5 per cent glucose daily (average); and if diarrhea is moderate to severe, approximately 1.5 to 3.0 Gm. of potassium chloride should be added to the glucose, per day. (Urine output is a good guide for fluid requirement.)

5. Diet—Bland, adequate in caloric and vitamin content.

6. Antibiotics—Sufficient to control infection.

   a. Aureomycin — Suggested dose of 250 mg. every 6 hours.

   b. Penicillin—Fortified, 400,000 units daily or every other day.

   c. Terramycin or Chloromycetin may be used.

7. Whole Blood—Administration of whole blood is usually not necessary until anemia develops which is at the end of the second or third week. Suggested amount is 500 cc. every 4 to 6 days. (Sufficient to control anemia.)

8. Oxygen—As indicated by condition of the patient.

9. Protamine sulfate or toluidine blue to control hemorrhagic tendency. The dose of these drugs is not definitely established. Suggested dose:

   a. Protamine sulfate, 1 per cent solution given slowly, intravenously in 100 mg. amounts. Repeated as necessary to maintain blood coagulation time within normal limits.

   b. Toluidine blue, 4 to 7 mg. per kilo of body weight, given daily intravenously.

SIX SURVIVAL SECRETS FOR ATOMIC ATTACKS

Always Put First Things First And

1. Try to Get Shielded

If you have time, get down in a basement or subway. Should you unexpectedly be caught out-of-doors, seek shelter alongside a building, or jump in any handy ditch or gutter.

2. Drop Flat on Ground or Floor

To keep from being tossed about and to lessen the chances of being struck by falling and flying objects, flatten out at the base of a wall, or at the bottom of a bank.

3. Bury Your Face in Your Arms

When you drop flat, hide your eyes in the crook of your elbow. That will protect your face from flash burns, prevent temporary blindness and keep flying objects out of your eyes.

Never Lose Your Head And

4. Don't Rush Outside Right After a Bombing

After an air burst, wait a few minutes, then go help to fight fires. After other kinds of bursts wait at least 1 hour to give lingering radiation some chance to die down.

5. Don't Take Chances With Food or Water in Open Containers

To prevent radioactive poisoning or disease, select your food and water with care. When there is reason to believe they may be contaminated, stick to canned and bottled things if possible.

6. Don't Start Rumors

In the confusion that follows a bombing, a single rumor might touch off a panic that could cost your life.

REMEMBER THESE SURVIVAL SECRETS. TELL YOUR PATIENTS ABOUT THEM.

Defense Against Biologic Agents Employed in Warfare

By JOHN W. BROWN, M. D.*
Madison

THE use of biologic agents in warfare presents potentialities of such significance that the subject should be afforded serious consideration in all plans for civil defense and for the treatment of casualties. Preparations to meet the almost infinite variety of possibilities implied demand flexibility in planning and operation, to the maximum extent compatible with effectiveness. For practical purposes certain aspects of the problem, such as prevention, early recognition, prompt reporting, decontamination, and treatment in every phase, are not separable. Each must be considered in all plans. Necessity will dictate the essential modifying features under the circumstances encountered. The following constitutes a brief summary of the nature of "biological warfare" and of certain protective measures which are simple and reasonable. The purpose is to suggest the variety of situations which may be encountered, but emphasizing that this brief summary is very limited in scope. The material is in substantial agreement with that contained in the "Blue Book," publication AG-11-1, Federal Civil Defense Administration, entitled, "Health Services and Special Weapons Defense," December 1950.

The practicing physicians of the state occupy an important position in the structure for defense against attack with biologic agents, particularly if employed against humans, but also if livestock are involved. Diseases of animals might become established in the human population with serious effects. The physicians can contribute crucial information. Each has a responsibility to report promptly any disease of unknown or questionable origin, especially if the source or other circumstances are suspicious. For the purpose, reports should not be limited to those specifically required by law. The State Health Officer will take appropriate action subsequently. The latter may consist of a request for specimens, the dispatch of an epidemiologist or a laboratory team to the scene, or be limited to correlation with other reports, as appropriate. The physician is a critical link in the chain. All should be aware of the responsibility within the structure for defense, understand that the possibilities are infinite, and that variants of common agents may be encountered. Although not necessarily the case, any infectious agent employed in warfare should be expected to resist the usual methods of control or to produce an unusual clinical picture. The veterinarians, agricultural bacteriologists, and pathologists of the state occupy a position similar to the physician. The efforts of each group should be coordinated.

The methods employed for the dissemination of biologic agents are likely to fall into two broad categories: (1) *Direct, overt attack, and* (2) *Dispersal insidiously by sabotage.* When direct and overt, the use of several infectious or toxic agents, coordinated in series and in conjunction with atomic weapons and chemical agents, may be envisioned. One possible method is by aerosol clouds of appropriate density and composition, dispersed by aircraft or other means so as to affect limited but critical objectives, perhaps industrial targets, and involving one or more areas of the country at the same time. The possibility is very real that an enemy could successfully deliver pathogenic agents or chemicals in this manner. Dissemination by sabotage may be most effectively employed to disable personnel in critical sites, but is particularly applicable against livestock and crops, employed insidiously over several months or a year, with the purpose of crippling the national economy, perhaps prior to overt attack. The simultaneous contamination of essential foodstuffs, water and milk, as well as the air of specific localities or buildings, might be accomplished by sabotage.

Protective Measures

Plans for protection should give consideration to those measures which may be applicable to protection against *all agents*, and those modified for specific situations. At the outset a successful defense depends in great measure upon the early recognition of the presence and nature of a biologic agent introduced for the purpose of attack. Coordination of the efforts of the medical profession, those concerned with agriculture and livestock, the state and local public health authorities, and selected laboratories becomes of immense importance. Leadership and control are provided by the director of health services (the state health officer). The health service is an extension of existing services. Early recognition of the dispersal of a biologic agent by sabotage is as vital as when by direct attack. A successful defense demands eternal vigilance to this end.

Effective reporting and rapid transmission of information take on added significance. The alertness of the practicing physician is crucial. This applies equally to the veterinarian, agricultural bacteriologist, and the pathologist. Preventive measures for humans are directed toward rigid safeguards of food and water supply in particular. Certain measures basic to defense against attack with biologic

*Member, Sub-Committee on Standard Therapy for Civil Defense, State Medical Society of Wisconsin.

Department of Preventive Medicine and Student Health, University of Wisconsin Medical School.

agents have been outlined in the "Blue Book" by the Federal Civil Defense Administration, referred to previously. Certain of the more fundamental and quickly applicable of these, and of suggestions from other sources, are abbreviated and somewhat modified in the following:

1. *Detection and Epidemic Intelligence*—As suggested, this depends especially upon the alertness of practicing physicians and selected observers, effectiveness of channels for reporting observations, the use of specialized laboratories (local, regional, and federal), development of specialized laboratory methods, and the efficient transmission of specimens and information wherever the facilities may be located.

2. *Personal Protection*—It would seem impractical, before the dissemination of an agent has been discovered, to attempt wholesale immunization of the population. However, the civil defense organization should be prepared to conduct a rapid program of immunization should an indication appear. The incubation period of the infectious or toxic agent, how early it is recognized, and the area involved initially will have a direct bearing on the practicability of protection by immunization.

Shelter—A degree of protection will be afforded if all whose duties permit seek shelter indoors and close off large portals of entry when an attempt to disseminate biologic agents by an airborne route is made. Everyone should wear clothing which covers the greatest part of the body. Much of the body surface will be protected by the clothing if it is then removed and decontaminated quickly after exposure. Dispersal through the air does not necessarily imply entry by way of the respiratory tract. Protection of the body surface can be the most important.

Environmental Sanitation—Cleanliness of the immediate environs is basic for the control of any epidemic disease. Elimination of insects and rodents assumes greater significance in the circumstances envisioned. Protection of foodstuffs and water, under cover, is essential. Ordinarily, food and water in sealed containers will be safe. When the danger of further contamination has passed, the container should be thoroughly scrubbed before opening. Boiling for one minute will destroy most pathogenic agents. Outside water supplies are open to suspicion after airborne dissemination of biologic agents. Unless effectively protected, water should always be boiled before use.

Clothing—Those exposed in the open during attack should remove their clothing under shelter, scrub generously, and redress in clothing which has been safely stored. Sunning and airing of contaminated clothing, rugs, furniture, and other items will be the most effective method of decontamination of these, when the airborne hazard has disappeared.

3. *Collective Protection*—If the nature of the hazard can be visualized in advance, the use of specially constructed shelters with adequate air filtering systems, and extension of air conditioning and air filtering systems for buildings and industrial plants will be a valuable aid in protection.

Decontamination—Sanitary engineers will participate, especially for this aspect of defense, as well as others. Most biologic agents will remain a hazard for only a short time in the open. Spores of pathogenic bacteria are an important exception. Many agents will remain viable in the dark and in the dried state, conditions to be found in buildings which have accumulated filth. After the danger from contamination from the outside is past, thorough airing, sunning, and cleansing with hypochlorite solution, cresol solution, or soap and water is effective in most of the circumstances visualized. The decontamination of clothing has been mentioned.

"Off Limits" Areas—It is probable that certain areas within a region may be found to have been dangerously contaminated and especially hazardous. Such areas would logically be considered "off limits" for all individuals except those whose duties require entry.

4. *Prevention of Epidemics*—The spread of any infectious disease will very likely be governed by the same general principles as at any other time. Control will, no doubt, involve methods which are part of every day practice. The application of measures for control will be modified as the situation dictates.

Drug Prophylaxis—The nature and character of an attack under some circumstances might indicate the use of one or more drugs to control infection by mass administration to the population as a whole. Obviously, this measure is not to be desired and would not be useful until the agent involved had been recognized and characterized. As in every other aspect of defense against attack with biologic agents, early recognition of the presence and nature of the agent employed is crucial.

Index of Suspicion of Infection—Before illness becomes manifest, the likelihood of infection in an exposed individual or group might be suggested, with sufficient accuracy for practical purposes, by careful evaluation of a situation as it develops. Factors which have a bearing include location with respect to greatest concentration of the pathogenic agent, the method of dispersal, character of the agent employed, and estimate of individual susceptibility. Selection as to segregation and isolation of individuals and groups might be accomplished with reasonable safety in varying circumstances. If successful, such action could reduce the number of effectives unnecessarily isolated and unable to perform their duties. Although methods for attaining these ends must remain obscure, the possibility of preventing an unnecessary loss of manpower in this manner should be considered. Success would conserve much needed personnel.

Management of Casualties

After an attack on a community, including its foodstuffs and animal population, the management of exposed persons becomes a primary consideration. The principles for protection outlined remain applicable. Measures for defense against and for treatment of casualties incurred by biologic agents are not easily separable. It is apparent that accurate estimates of methods and supplies required for treatment are hardly possible in advance. Those responsible must be opportunists, recognizing and improvising as circumstances dictate. Each item used in the treatment of diseases caused by any infectious or toxic agent might conceivably be needed in maximum amounts. The problem consists essentially of an estimation of infectiousness of the agent employed, appropriate isolation to prevent spread of disease without unnecessary loss of the number of effectives in the population, and finally, treatment of casualties, general and specific.

The *initial evaluation* of the condition and appropriate procedure for an exposed individual is a duty of the team responsible for sorting all casualties on the scene. This avoids duplication, but demands that the personnel are aware of the principles peculiar to "biological warfare." Central stations should have available certain personnel who are the best qualified to evaluate difficult problems and to suggest general and specific measures for management of the situation created by the presence of biologic agents. The emergency tag of each individual should indicate the location at time of exposure and provide directions for subsequent management in so far as determined at that time. It should be remembered that not all biologic agents under consideration cause a communicable disease.

The need for hospital care will depend upon several factors. Extensive procedures or hospital facilities will probably not be required for casualties due to biologic agents alone. Any shelter under supervision will suffice.

Casualties suffering *combined effects* of exposure to atomic weapons and biologic agents can create the most difficult situation. Most, if not all, casualties might present a combination of injuries. Under these circumstances, when the isolation of casualties to control the spread of epidemic disease is essential, special isolation sections in hospitals equipped to provide treatment for injuries of all types will be needed.

Widespread dissemination of infectious agents with a *high degree of communicability* must be anticipated. If this should be successful, almost everyone in the area involved would have to be considered a potential source of infection. This would immobilize the personnel of the entire locality. Most services would of necessity be supplied by the uninvolved support areas, at least, temporarily. The morbidity rate might not be high, but inability to perform most essential duties could be almost complete.

Supplies—A few specific items will probably be required in most circumstances, either for prevention, control, or treatment. In brief, the minimum needs will include a large supply of potent *insecticides* and *rodent exterminators* for the contingency wherein agents transmitted by insects or rodents are employed, and also to control the pest population under any circumstances which disrupt local environmental sanitation. *BAL* (British Anti-lewisite) in both ointment and injectable form should be at hand for patients who suffer injury to the eye, skin, through the respiratory tract, or by ingestion of chemicals which may be disseminated, especially arsenic and mercury containing compounds. *Atropine sulfate* should be available on the assumption that chemical agents of the "nerve gas" type might be used. Atropine is the specific antidote. The intravenous route is preferred. Local installation into the conjunctival sac may be necessary as well. This reference to chemical agents is made because the principles involved in attack and early recognition of casualties have features in common with biologic agents. *Antimicrobial drugs*, especially those with the widest spectrum of activity and minimum toxicity, will undoubtedly be required. Infections incurred in biologic warfare may possess characteristics which have not been encountered previously, even though the etiologic agent is easily recognized. Any drug or item of supply used in the treatment of diseases caused by any infectious or toxic agent could conceivably be needed in maximum amounts for all casualties. The potentialities are so great that further discussion of therapy would not be profitable.

Conclusion

The variables incident to defense against biologic agents employed in warfare, and the treatment of casualties incurred, present an infinite variety of possibilities. Flexibility in plans is considered of paramount importance. It is emphasized that an overt attack with biologic agents may be coordinated with various methods employing atomic, and chemical weapons in addition, to result in a combination of injuries to the same individual. The use of several infectious or toxic agents at the same time should be anticipated. Early recognition and definition of the presence and nature of attack with biologic agents is crucial for defense. This aspect is of equal or greater importance when insidious methods of dissemination by sabotage are employed. The practicing physicians, veterinarians, agricultural bacteriologists, and pathologists occupy important positions in the structure for defense.

THE MEDICAL FORUM

COURT HEARS DEMURRER ARGUED IN PHARMACY CASE

NBC Stations Carry New Health Program

Madison, June 10.—NBC radio stations in Wisconsin are broadcasting a news series entitled "Your Key to Health" bringing facts and information about improvements and health facilities and services, news of the battles being waged against unconquered disease, and human interest stories describing how people in communities are helping themselves to better health.

The following stations carry the program in Wisconsin:

WIBA, Madison
WEAU, Eau Claire
WKBH, La Crosse
WMAM, Marinette
WTMJ, Milwaukee
WSAU, Wausau

The programs may be heard each Saturday according to local radio schedules. They are produced jointly by the National Broadcasting Company and the Health Information Foundation. They feature stars of radio, stage and screen as announcers and actors.

Congress Can't Decide on Need for EMIC

Washington, D. C., May 14.—Conflicting recommendations on EMIC (Emergency Maternal and Infant Care) have come out of hearings and reports in Washington.

The Bureau of the Budget has informed Congress that it cannot recommend enactment of EMIC at this time and that it opposes free hospitalization of dependents of servicemen.

In contrast, the Department of Defense and the Children's Bureau urged passage of an EMIC program, in particular, the bill by Senator Herbert Lehman (D., N.Y.) which would provide hospitalization for all dependents of servicemen.

Few M.D. Deferments After Jan. 1, 1953

Washington, D. C., June 1.—Deferments for physicians on the basis of essentiality are extremely unlikely after January 1, 1953, with the exception of private practitioners in isolated rural areas, according to the National Advisory Committee to Selective Service.

The Advisory Committee recommends no deferments beyond January 1, 1953, except in unusually critical circumstances. The Committee has adopted this policy in view of the fact that some 2,500 physicians currently on military duty will complete their service between now and January 1 and should serve as an adequate source of supply to replace other available Priority I physicians.

Medical Society Aids in Summer Course

Madison, June 5.—The State Medical Society is assisting the University of Wisconsin School of Commerce in presenting a series of workshop sessions during the summer on family financial security education.

The program is offered to high school teachers, administrators, and faculty members of teacher training institutions. The purpose of the courses is to teach the students the fundamental principles of managing incomes and saving money.

The State Medical Society's role in the workshop sessions will be to provide information on how to budget for medical and surgical expenses through the various voluntary prepayment health programs offered under the sponsorship and approval of the State Medical Society.

CLAIM DOCTORS' RIGHTS VIOLATED

Madison, June 5.—The Attorney General contends that the suit of the Wisconsin Pharmaceutical Association against the Wisconsin State Board of Pharmacy should be dropped because it is an attempt to determine the rights of physicians without their having an opportunity to be heard.

This argument was advanced by Attorney General Vernon W. Thomson and Assistant Attorney General Warren H. Resh at a hearing in Dane County Circuit Court on June 5.

No Opinion Yet

They act as attorneys for the Board of Pharmacy, and seek a demurrer to the complaint. They argue that the complaint has certain legal defects and omissions which make it unnecessary to answer.

The court had not rendered an opinion on the demurrer at the time *The Medical Forum* went to press.

The pharmaceutical association has asked for a judgment interpreting the "Dangerous Drug Law" to include "unqualified persons employed in physicians' offices and prohibiting such persons from preparing, compounding, dispensing or delivering dangerous drugs."

Action Affects Doctors

The Attorney General has held that such persons may count out, package and deliver drugs to the physician's patients providing these tasks are done under his supervision and direction.

During the court hearing, Mr. Resh pointed out that the "gist of the action relates to the activities, not of the Board of Pharmacy, but rather physicians and their employees none of whom are parties to the action."

To continue the action proposed

(Continued on page 588)

PHARMACISTS . . .

(Continued from page 587)

by the pharmaceutical association would be a "violation of the fundamental American concept that every man is entitled to his day in court where his rights are concerned," Mr. Resh contended.

Mr. Resh also argued that the pharmaceutical association complaint does not state enough facts to constitute a cause of action. He pointed out that both parties to the suit are pharmacists who have "no true adversity of interest," but merely a difference of opinion as to how the statute should apply to physicians.

Mr. Resh said that "what the plaintiffs are seeking is a declaratory judgment as to the scope of the exemption granted physicians from the provisions of the Pharmacy act. Since the exemption does not apply to pharmacists they are not entitled to any relief as to how it may apply to others."

Attorneys for the pharmaceutical association opposed the demurrer on the ground that the presence of physicians as parties to the action is "neither useful nor necessary to the determination of the case."

The attorney argued that the only question involved is whether the Attorney General's interpretation of the Dangerous Drug Law is consistent with the law and the intent of the legislature.

Charge Discrimination

"The Attorney General's ruling is discriminatory. It makes no real distintion between girls employed by pharmacists and girls employed by doctors," pharmaceutical association counsel said. "There is no greater reason for the doctor to order his office girl to handle dangerous drugs that there is for soda fountain girls to do the same thing. The law says the pharmacist can't delegate this task. It should apply equally to doctors."

In rebuttal, Mr. Resh said that "if the legislature had intended to restrict the physician in the same way as the druggist, it would have said so." He contended that the existence of a doctor–patient relationship makes it possible for the physician to delegate certain tasks without violation of the pharmacy act.

WIBA Starts Unique Safety Campaign

Madison, June 10.—A unique safety campaign has been started by Madison Radio Station WIBA and with the assistance of local physicians, hospitals, and nurses.

Throughout the recent Memorial day weekend, station WIBA repeatedly broadcast short tape recordings urging motorists and vacationers to "take it easy" and enjoy a safe and sane weekend.

The tape recordings were made on the spot in the emergency rooms of several Madison hospitals. Physicians, nurses and ambulance drivers were interviewed and their warnings recorded.

Personal Warnings

For example, a physician, usually an intern or resident, would identify himself and express the hope that he would not be required to treat any of the listeners during the weekend that he was on duty. Similar remarks came from nurses and ambulance drivers and others associated with the emergency care and treatment of accident cases.

ORIENTATION PLAN FOR YOUNG M.D.s

Chicago, June 1.—A special "orientation" program for graduating medical students of Nebraska's two medical schools was held recently under the sponsorship of the Rural Medical Service Committee of the Nebraska State Medical Association.

The program, which is to be an annual event, honors graduating medical students and presents information to help the students make the plunge from medical school into internship, residency and medical practice.

Talks were presented to the senior students on the advantages of small town practice, the mechanics of establishing an office, the physician's obligation to his community, medical ethics—the doctors golden rule, the function and relationship of county and state medical organizations and the American Medical Association as a colleague in practicing medicine.

Several of the students commented upon the meeting to the effect that "I'm glad I heard some of these things today rather than running into them cold after I get out of school."

New Wagner–Dingell Bill May Be Featured as Party Plank Issue

Washington, D. C., April 14.—A new Murray–Dingell bill is before Congress. It may revive the feuding over "socialized medicine."

Senator James E. Murray (D., Mont.) and Rep. John D. Dingell (D., Mich.) have filled S. 3001 and HR 7484, identical bills that would make an estimated 7 million social security beneficiaries eligible for government-paid hospital care.

The measure was composed by experts in Federal Security Agency whose chief, Oscar R. Ewing, issued a statement strongly recommending enactment.

The bills offer up to 60 days hospitalization per year to social security beneficiaries over 65 and to surviving dependents of workers who were insured under OASI at the time of death. Only hospital services will be paid for under this plan. No medical or surgical care is provided.

Decentralized operation of the program, under the direction of various state governments, is provided for and participation of Blue Cross and other nonprofit organizations is authorized by the legislation.

Cost of the program in 1953 is estimated at $200 million.

Murray and Dingell are fishing for rank-and-file support among physicians when they say their plan would be a boon not only to the indigent, state and local governments and hospitals but to physicians as well. They explain that doctors will stand a much better chance to collect their own bills promptly and in full once the hospital bill is out of the way.

Gerald Gross, editor of the "Washington Report on the Medical Sciences," suspects that this "free hospitalization" plank probably will be featured prominently in platforms of labor-supported and liberal candidates for national office. It will be held out as a social security gain obtainable without new taxation or increasing social security premium payments.

DOCTORS TO ASSIST WITH STATE-WIDE SURVEY OF NURSING EDUCATION

Madison, May 19.—A state-wide survey of nursing education has been approved by the Wisconsin State Board of Nursing.

Allied professional groups are being invited to nominate persons to serve on an advisory committee which will define the scope of the study and act in an advisory capacity to the research and consultant staff.

The state medical society has been asked to submit the names of three physicians in private practice and three physicians associated with medical schools which are associated with schools of nursing.

Also represented on the advisory committee will be two hospital organizations, the state nursing organizations, and three persons representing tht general public, the consumers of nursing, and two representatives from general education.

The Board of Nursing said that it is: "increasingly concerned with the lack of qualified nurses, both graduate, registered and trained practical, to care for the sick. It is evident that this acute situation may become more severe, and thereby impede the recovery of the sick.

"It recognizes, further, that the education of nurses is paramount to good nursing service, and the continued shortage of qualified instructors limits the number and quality of nurses being prepared."

It is anticipated that the study will get under way sometime in 1952.

Health Commission Hears Dr. Sander

Washington, D. C., May 27.—Dr. O. A. Sander, Milwaukee, a member of the Council on Industrial Health of the AMA was one of the participants in a panel on Industrial Health that is part of the President's Commission on the Health Needs of the Nation.

Other panels which have been meeting recently are those relating to medical research and the supply and training of nurses.

FDA Clamps Down on Over-the-Counter Sales of Rx Drugs

Washington, D. C., April 17.—Illegal sale of sleeping pill drugs brought a six-month jail sentence to a Seattle druggist, according to a release by the Food and Drug Administration.

His illegal sales of sleeping capsules to skid row derelicts and delinquents had caused a serious police problem in Seattle.

Four other cases brought in March for illegal sales of prescription drugs resulted in fines for pharmacists and drug stores. This is part of the Food and Drug Administration's stepped up campaign to eliminate over-the-counter sales of prescription drugs.

Another case, a jail sentence was imposed on "Dr." Joseph C. Mills, Tucson, Ariz., for shipping an unlabeled male sex hormone to California to a customer who distributed the drug in a Chinese community to "increase sexual virility." It was purchased for $1.75 and sold for $60.

During the month of March the Food and Drug Administration also seized 149 shipments reported in violation of the Federal Food, Drug and Cosmetic Act.

Kubiak is Now Rehabilitation Chief

Madison, April 15.—Mr. John A. Kubiak has been appointed chief of Vocational Rehabilitation by the Wisconsin State Board of Vocational and Adult Education.

He assumed active responsibility in this position on April 1. For a number of years Mr. Kubiak served as local coordinator of vocational rehabilitation for the City of Wausau and four counties in the north central part of the state. During recent years he has been supervisor of occupation information and counselling for the State Board of Vocational and Adult Education.

Mr. Kubiak replaces Mr. W. F. Faulkes who retired as chief of the Rehabilitation Division on December 31, 1951.

Moral: Don't Drive on Saturdays

Hartford, Conn., Apr. 15.—Nearly two million casualties were recorded as a result of automobile accidents in 1951, according to a recent survey.

Last year's traffic deaths totaled 37,100. The injury count went up to 1,962,000.

Drivers exceeding the speed limit accounted for 13,000 persons killed and 570,000 injured, according to the statistics from Travelers Insurance Companies.

Drivers under 25 accounted for 11,000 fatalities and 416,000 injured. Saturday was the most dangerous day of the week to drive. Most persons lost their lives from 6 to 7 p.m., and injuries hit their peak from 4 to 5 p.m.

CLAIM BLANKS

A Wisconsin doctor is likely to handle more TIME claim blanks than any other company's. TIME, a leader in the accident and health insurance field, insures a large portion of the total number of persons carrying such insurance in Wisconsin.

Few doctors appreciate the great service given to their patients when these claim forms are handled promptly.

Any suggestions from you as to how our claim forms may be improved will certainly be appreciated.

• • •

The Time Insurance Company

813 WEST WISCONSIN AVENUE

Milwaukee 3, Wis.

THREE CLINIC MANAGERS met at the medical society recently to consult on a new and improved Physicians Service Report for Wisconsin Physicians Service. They are (l. to r.) Arthur Gullickson, Madison; William Wilcox, Black River Falls, and Floyd Detert, Marshfield.

Doctors Donate Time for "Bloodmobile"

Appleton, May 25.—Members of the Outagamie County Medical Society donated their time to the Red Cross "Blood for Defense" program when the bloodmobile visited the county recently.

The physicians served the unit in an emergency measure because the regional blood center was short of physicians to travel with the unit.

According to Dr. Louis B. McBain, president of the County Medical Society, the physicians in the county donated their time in one hour shifts for three days to make blood tests, take medical history and supervise the donations. The bloodmobile visited Appleton, Little Chute and Kaukauna.

Order Firm to Stop Mail Order Methods

Washington, D. C., May 13.—The Federal Trade Commission has issued a decision forbidding the A. C. Liepe Pharmacy, Inc., of Milwaukee from using "mail order methods" of diagnosis and treatment to promote sale of the firm's medicinal preparations.

The company used questionnaires and report forms, on the basis of which patients' illnesses were diagnosed and products known as Liepe Methods were prescribed for treatment.

The decision will become final unless appealed or docketed by the Commission for review.

Cleveland Doctors Set Up "Full Payment" Plan With Insurance Carriers

Cleveland, March 5.—Under an arrangement with 1,200 Cleveland physicians, some commercial insurance carriers are now offering service-type benefits similar to Blue Shield's. The new program, called the Cleveland Academy Medical Care Plan, guarantees full payment of bills for in-hospital surgical and medical services covered, so long as such bills are incurred by families earning less than $5,000 a year.

Here is how M.D. participation was arranged:

First, the doctors signed contracts with the Cleveland Academy of Medicine, agreeing not to charge more than the ceiling fees listed for various services.

Then the Academy filed these charges with the insurance carriers, making it possible for them to quote premium rates.

Dietetic Internships Offered in Milwaukee

Comprehensive Training in 12 Month Course

Milwaukee, May 1.—An unusual opportunity for a career in dietetics is being offered through an approved graduate course in hospital dietetics at the Milwaukee County Institutions.

The course is designed to offer college graduates with a major in home economics or foods and nutrition, a year of practical training and experience which qualified the intern for a career in hospital dietetics or allied fields.

Offer Special Training

About half of the intern's year is spent at Milwaukee County General Hospital for basic instruction. Rotation through the special hospitals of the institution gives the intern a chance to study the dietary programs required for young and old, mentally ill, the tuberculous and the general hospital patient.

In addition, the intern is acquainted with the dietary services of Columbia Hospital and Gimbel Brothers.

Work 40-Hour Week

One class of 12 is admitted each year in August. Applications must be made before March 1. Candidates must be at least 21 years of age and have a Bachelor's Degree from an accredited college or university. The course runs for 12 months. Interns work a 40 hour week, exclusive of class time.

Receive Cash Allowance

Room, board, laundry and medical care are furnished by the hospital. Each intern receives a monthly cash stipend of $15. Upon completion of the course, the intern receives a certificate and pin, and becomes eligible for membership in the American Dietetic Association.

Persons interested are requested to contact the Director of Dietetic Internships, Milwaukee County Institutions, Milwaukee 13, Wis.

VA RESTRICTS USE OF STREPTOMYCIN AND PAS

M.D.s MUST GET PRIOR AUTHORIZATION FOR OUTPATIENT USE OF THESE DRUGS

Milwaukee, May 21.—The Veterans Administration has established a very definite policy in regard to the use of Streptomycin and Para-aminosalicylic Acid (PAS) and their salts for the treatment of tuberculosis on an outpatient basis. These policies were effective May 1, 1952.

All Wisconsin physicians treating veterans on an outpatient basis are requested to review the essentials of this policy:

a. The initial course of treatment with Streptomycin and PAS must be given in a hospital upon the recommendation of the discharging hospital. The patient may be referred to a fee basis physician for continuing treatment with the drugs. If this occurs, the hospital's recommendations as to dosage and frequency thereof plus any other instructions which involve the individual patient, will be furnished to the fee basis physician along with the necessary pertinent information from the hospital report to carry out recommended treatment.

b. Fee basis physicians will be requested to forward prescriptions for Streptomycin and PAS to the Regional Office for filling. They will, likewise, be requested to furnish this office detailed progress reports, including dosage regimens at monthly intervals on all patients under treatment. Without such reports, continuing treatment will not be authorized.

c. Fee basis physicians will not be authorized to use Streptomycin or PAS for outpatient treatment of tuberculosis on eligible patients without *prior* approval of the Regional Office.

Whenever in the future the V. A. issues an authorization for outpatient treatment for examination of TB patients it will include a statement on the authorization as follows:

"Streptomycin and PAS and their salts will not be prescribed for outpatient treatment of tuberculosis for any VA beneficiary without prior approval from the Veterans Administration Office."

Call 232 Physicians to Duty in July

Washington, D. C., April 14.—The Army has disclosed that it is issuing orders for two years active duty beginning in July to 232 physicians. This latest summons will be made upon members of the reserve corps who came from Priority I in the Selective Service processing.

Britons Start Charging for "Free" Services

London, June 1.—Final approval has been given to a Conservative-sponsored health bill designed to charge Britons for certain health services they are now receiving "free."

The vote on the bill which had posed a serious threat to Prime Minister Winston Churchill's government, was 284 to 266. It was the first major piece of legislation to be put through Commons by the conservatives since they came to power last October.

The main charges to be imposed on patients under the new bill are one shilling (14 cents) for prescriptions; charges of up to one pound ($2.80) for dental treatment, and charges of roughly one-half the cost for such appliances as surgical boots, surgical abdominal supports, elastic stockings and wigs, which now cost two pounds, 10 shillings ($7).

Green County Society Aids Safety Project

Monroe, May 15.—The Green County Medical Society is participating in a safety project in cooperation with the Green County Safety Council.

Dr. E. E. Eckstam, of the Monroe Clinic, Monroe, recently discussed accident prevention and good safety methods with members of the Council.

Projects being undertaken by the group include the bicycle safety program, 4-H Club safety plans, emphasis on safety and education of pupils at school, and a project for posting gummed labels worded "danger" at various danger points on Green County farms.

ILO Asks Insurance for Working Mothers

Washington, D. C., May 13.—The International Labor Organization has reported a proposal for an international labor convention to "further progress in the protection of working mothers."

Under the proposal, women in both industrial and non-industrial jobs would be eligible for twelve weeks of maternity leave before and after confinement. Cash and medical benefits would be "sufficient for the full and healthy maintenance of mother and child in accordance with a suitable standard of living."

The ILO statement adds: "These cash and medical benefits would be provided either under compulsory social insurance or out of public funds."

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"Too Many Chips on Too Many Shoulders" A Forum Feature

A REPORTER'S VIEWS ON PRESS-MEDICAL RELATIONS

by
JOHN NEWHOUSE

Ed. Note: Mr. Newhouse is a staff reporter for the Wisconsin State Journal, Madison. He was a speaker at the Medical–Press Conference in Madison, May 5, and was invited to present his views in more detail through the Medical Forum.

There are undoubtedly times when the medical profession wishes that the press would take a flying jump in the lake with its bothersome questions, and let the doctors go about their work in peace.

And there are times when the press bangs a phone on the hook and vows—none too silently—that it will be a cold day before it tries to get information out of a doctor again.

But, in this complicated world, neither course is practical.

The press, if it is to do an honest job of keeping its readers informed, needs the help of the doctor in reporting the news, from the accident on the street to the newest in medical science.

And the doctor, in this day when an electorate can be manipulated to vote to socialize a profession or an industry, is dependent more than ever upon the press to bring a balanced and unbiased picture of its activities to the voting public.

Two Troublesome "Chips"

There are a pair of major fields of irritation between press and physician which have resulted in too many chips on too many shoulders. And it should be possible to remove these chips by some means other than bad tempered brawling.

One field is that of accident reporting, when the question becomes how much the doctor can reveal about his patient's injuries and condition.

The other is that of news stories involving the use of a doctor's name, which he is prone to consider "advertising," and hence "unethical."

For an example of the first:

Joe Doakes and John Jones smash their cars on Main St. and are taken to different hospitals, where they are cared for by different doctors.

A reporter, one eye on the clock and the other on his city editor, has to learn the answers to two questions that friends and relatives will want to know, as well as the public.

He can't leave his story dangling, with the men taken bleeding and moaning, perhaps, to the hospital. He has to know, in general terms, what the injuries were and what their condition is.

"Call it head injuries," says Doake's doctor, who is used to dealing with the press. "Off the record, the back of his head is caved in. Condition? Call it critical. Off the record again, I doubt he'll make it. Better call me in a couple of hours."

1839 Statute Applies

The reporter writes that Doakes suffered head injuries and that his condition is critical, and blesses the doctor who tipped him off to watch for further developments.

Then he calls Jones' doctor, and Jones' doctor isn't sure just what he can say. This basic insecurity puts him on the defensive, and he resents being prodded in the manner that a reporter, a few minutes off deadline, can be tempted to prod.

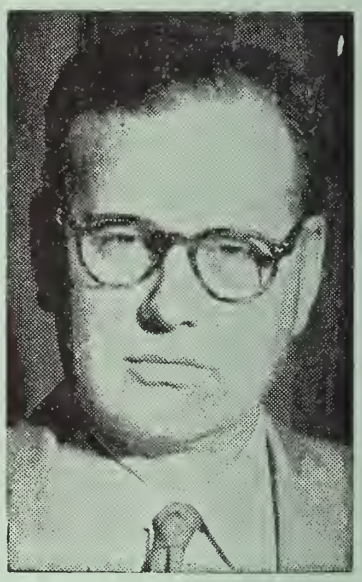
And, in a couple of minutes, a pair of lifetime animosities running between individuals—and the professions they represent—can be whipped up.

And the reporter, turning to the man next to him, is asking, "Why in blazes can't these doctors agree on a uniform policy on what they can tell the press?"

At the basis of this indecision is a statute adopted in 1839, when Wisconsin was a territory and a newspaper something that was printed in the effete East.

Entitled "Communications to Doctors," the statute (Sect. 325:21) says bluntly, "No physician or surgeon shall be permitted to disclose any information that he may have acquired in attending any patient in a professional character, necessary to enable him to professionally serve such patient . . ." and goes on to list four exceptions.

The doctor may testify in homicide trials, in lunacy inquiries, in



JOHN NEWHOUSE

actions against him for malpractice, and may give information in certain life insurance inquiries.

It apparently imposes far greater restrictions upon the doctor than on the non-doctor in matters which are normally not kept secret.

Johnny can fall out of a tree and break his arm, and the man next door can relay this information to his wife and friends. A reporter can print the fact in the paper.

But, under a strict construction of this statute, a doctor apparently can't meet Johnny's aunt on the street and say, casually, "Johnny broke his arm this afternoon, but he's coming along fine."

Should Law Be Changed?

Actually, according to the legal authority of the state medical society, there have been no cases brought under this 113-year-old law.

The guess of this reporter is that the framers of the law wanted to protect the patient in his relationship with the doctor when it is imperative that the patient make revelations to the doctor necessary for his treatment but which could be embarrassing if given wide circulation.

As it stands, the law exists as a potential danger to the doctor

from the crank who conceivably could press charges for such things as "Johnny broke his arm this afternoon."

But the danger of a decision against the doctor is slight in this instance. A person is not "damaged" much if the public knows that he has a broken limb. It is no disgrace.

On the other hand, the century old law has been amended several times by the legislature. It could easily be amended again, with the weight of the state medical society behind such a move, to protect the medical man except as he wilfully revealed information which would tend to embarrass the patient or cause him financial loss.

With a sound law on the books, the next step would be the preparation of a glossary of terms to be used in dealing with the press, and the dissemination of this information through medical journals and medical colleges in training of students.

And one of the major irritants between press and physician would be eliminated.

Use of Doctor's Name

A second major irritant lies in the writing of medical stories where the doctor's name legitimately should be used. This is important to the reporter, for it gives authority and credence to his story.

It gives credit where credit is due, and it attaches reponsibility for the story where it belongs. In every other profession, the reporter uses names, and his paper would lose faith with its readers if it did not cite sources.

What About It, Doctor?

This article expresses the views of an experienced and able newspaperman on the problems he faces in working with physicians.

His opinions jibe, by and large, with those of other newspaper and radio reporters contacted in the recent series of Medical–Press conferences.

What do you think, Doctor? What about his suggestions for improving press relations? What are your views on this important problem?

Send your comments to the Medical Forum, 704 E. Gorham Street, Madison 3.

Here is an instance of what can happen:

An up and coming surgeon has a patient hemorrhaging through the veins of the esophagus, slowly bleeding to death. So he reroutes an artery draining the area in a bold operation that lessens pressure on the bleeding veins, and the patient recovers—the first time such an operation has been performed in the city.

The reporter hears of it. The doctor is willing to have a story written. The city editor schedules it for the paper the next day. The reporter writes the story.

And three things can happen.

The bogy-man of "advertising" can rear its ugly head and the reporter has to rewrite the story to leave the doctor's name out.

Or it can go through with the doctor's name in it, and nothing happens.

Or it goes through with the doctor's name in it, and the roof may fall in as a medical society swings into action to chastise the erring doctor.

The doctor, smarting from criticism, is through talking with the press. And the reporter winces a little when he hears of the next story involving doctors.

"If they had a uniform policy, it would be all right," he grumbles to the man next to him. "But this way . . . maybe I get away with it, and maybe I get a good friend in Dutch with his profession and he gets mad at me, to boot."

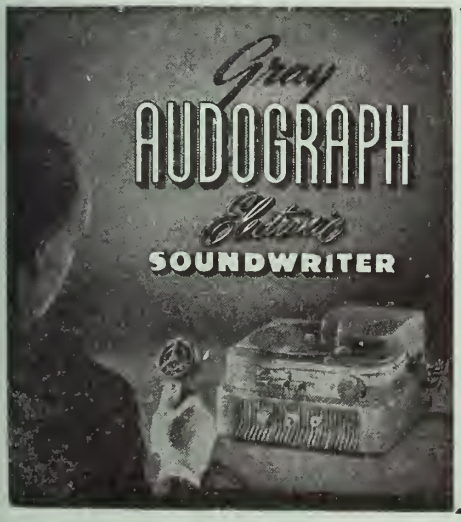
So he writes some other story.

The trouble, in part, is a matter of semantics, stemming from the loose defining of the term "advertising."

"Advertising" is space you buy in the paper. You pay money for it, and in it you toot your own horn. If a doctor advertises, in the true sense of the word, the man with the most money—though possibly not the most skill—could get the most business.

Lawmakers had this construction in mind at the turn of the century when they adopted a statute (Sect. 147:20) when they forbade doctors from advertising cures for "venereal diseases, the restoration of lost manhood, the treatment and curing of private diseases peculiar to women, or the advertising or holding himself to the public as a specialist in diseases of the sexual organs, or diseases caused by sexual weakness, self abuse, or excessive indulgences . . ."

From the Civil War on, newspapers carried advertisements of



A PROVEN AID FOR MDs

The GRAY AUDOGRAPH is not an experimental machine for doctors. Hundreds in and around Wisconsin are using it with complete satisfaction, as a means of speeding up their office work and increasing the efficiency of their secretarial help.

A Few Users in Madison . . .

STATE MEDICAL SOCIETY
DIV. MENTAL HYGIENE, DEPT. OF PUBLIC WELFARE
AMERICAN BOARD OF INTERNAL MEDICINE
WISCONSIN DIV., AMERICAN CANCER SOCIETY
JACKSON CLINIC — VA HOSPITAL
ALBERT BONER, M.D. — WILLIAM LEWIS, M.D.
STUART McCORMICK, M.D. — RAY LUDDEN, M.D.

Let us demonstrate how this machine can serve you. No obligation . . . let us know what time and day would be most convenient. A representative is near your office.

JOHN NICHOLS, Inc.
541 N. BROADWAY — MILWAUKEE 2, WIS.

DR. D. E. DORCHESTER, Sturgeon Bay, chairman of the Council on Medical Service, presides at the Appleton Medical-Press Conference. Seated beside him are the program speakers, Mr. Joseph Horner, Jr., business manager of the Green Bay Press-Gazette, and Dr. Guy W. Carlson, Appleton.

this type, designed to frighten young men and women into buying nostrums no more practical than the electric belts of that day, and the statute was adopted to stop just that practice.

When the doctor cries "advertising," broadening the term to include legitimate news, he is forgetting what has happened to his profession—public relations wise—in the last half century or so and the price he is paying for the security that his medical society offers.

Times Have Changed

When Old Doc's horse clip-clopped down the streets a half century ago, his friends rolled over in their warm beds and blessed the old boy. They knew about when he carried the Widow Johnson's bills on the books 'til he tore them up.

When the kids were sick, he came to the house, and he snitched a cookie from Mama in lieu of dinner when he was in a hurry.

On the other hand, if three of his patients perversely decided to die in a week, he weathered out the criticism of the Ladies Aid or—if he couldn't cut the buck—quit.

Things have changed today. Cities are bigger. The old horse has been retired. Doctors treat people in cubicles. Patients often don't know each other. There are so many specialists that a man may see his bevy of doctors only on an average of an hour or so a year. And more and more people die in hospitals.

(Right here, this reporter would like to add that he has a doctor, probably the finest in Madison, who does come to the house.)

Newspapers aid in shielding the doctor from criticism. We don't say, "Two more of Dr. Blank's patients died today." We simply state that so-and-so died. We don't state that so-and-so died at a specific hospital. We say that death occurred at "a hospital."

Then why the need for better relations between press and physician?

There are a number of reasons.

For one, people have a natural concern in the illness of others, or the accidents which occur to them, so far as that story can decently be told.

Teamwork Needed

For another, there may be readers within our circulation areas who don't realize that some new technique, some new drug, may prolong their lives, or give them better lives while they're here.

And for another, this is the day when a fickle public can vote to do as it blamed well pleases.

The doctor of today can save lives where Old Doc didn't have a chance, and he can do it under a system in which he pretty much controls his own business.

But no matter how well he serves the public, he cannot preserve that system unless the public knows what he is doing—as far as it can know—and feels that it is getting the best service possible.

That feeling is built up over the years by honest and full reporting of what is going on, with ethical doctors dealing with ethical newspapermen forming a good working team for the good of the public.

Papers Defend Medicine

For years, the press has been rebuffed by physicians from time to time, gritted its teeth, and gone on writing stories about the need for more hospitals, for nurses aides, for rare types of blood—all the legitimate demands made by physicians upon the press.

More than that, the press has generally defended the right of the physician to run his own business—even though the press might be tempted at times to "get even" with the so-and-so's.

That's a part of the ethics of a good newspaperman—he can't let personal pique sway him from what he knows is the truth, or—editorially—from writing what he believes to be in the public interest.

If the press, generally, had said to blazes with doctors a decade ago, and swung editorial page support to promulgators of socialized medicine, there is little doubt but that that system would prevail in this country today.

Better relations cannot be achieved over night. Sincere efforts on both sides may result in each cussing the other out. There are some "outlaws" in our profession, and—we suspect—in the doctor's. But, over the years, a lot can be accomplished by trying.

Public Relations Tip

Do you have the AMA's public relations plaque on your reception desk? It is an effective way to invite patients to discuss your fees or services. Get your plaque by sending $1.00 to the State Medical Society, 704 E. Gorham St., Madison.

The Local Hospital and Civil Defense

By H. C. JOHNSTON, M. D.,[1] FRANKLIN D. CARR,[2] and KARL YORK[3]
Madison Waukesha Racine

HOSPITALS are the focal points for civil defense. If an atomic attack were to result in the 60,000 casualties as estimated for a city like Milwaukee, about 40,000 survivors would be in need of medical care. About two-thirds of these, or 26,000 persons, would need hospital care. It is generally agreed that hospitals within an 80 mile radius of the disaster point may be called on within a few hours at most to serve a vast number of casualties numbering at least twice the normal peacetime capacity of the community. In subsequent hours or days, hospitals beyond the 80 mile radius from the attack center would be called upon to take on the additional load that is certain to develop.

Hospitals will be called upon by legally constituted authority on the state and local levels to respond to a disaster emergency.

The Role of the Hospital in Local Civil Defense

The role of the hospital is primarily to provide care for all types of acute medical and surgical patients, both casualty and non-casualty, and, secondarily, to provide emergency care for the less severely injured in improvised auxiliary buildings.

The hospital is an essential part of the local civil defense organization and should be closely integrated with it. The whole national and state civil defense program is based and dependent upon action primarily at the local level in existing and available facilities. Therefore, the effectiveness of the hospital in a civil defense emergency is dependent entirely on locally prearranged plans.

In actual practice, the hospital must take the initiative in meeting its disaster requirements. It must assume responsibility for the provision and organization of nonprofessional personnel, as well as the medical staff personnel, to serve the acute medical and surgical patients, together with providing supplies and auxiliary services either through its own organization or in conjunction with other services of the local civil defense organization. It must also provide for auxiliary buildings such as schools, hotels, churches, and other large meeting places in which to serve the less severely injured. The auxiliary buildings would be requisitioned through the local civil defense authority and should be organized, staff provided, and supplies provided under the direction of the hospital administrator but with the cooperation and exercise of authority of the local civil defense director.

Each hospital within an 80 mile radius of a disaster which is augmented with prearranged auxiliary facilities can be expected to care for casualty patients numbering at least twice the hospital's normal peacetime capacity.

Requirements of the Local Hospital Disaster Plan

1. To establish a means and method for alerting personnel at the time of a disaster.
2. To place the hospital and its auxiliary facilities, such as the evacuation and receiving facilities, in a readiness-to-serve condition.
3. To begin the evacuation of the nondisaster patients in the hospital, which can be expected to be at least 75 per cent of the patients in the hospital at that time.
4. To set up all possible additional beds.
5. To establish contact with allied services under the civil defense organization to make certain that other related functions are being carried out.

All elements of the plan must be coordinated and integrated with the greatest dispatch because the complexity of organization and the severe limitations imposed by the time element may make the local civil defense disaster plan ineffective. Every element in the plan is involved in the hospital's treatment of casualties.

Suggested Hospital Plan for Disaster Management

The following is a plan which can be used as a guide by any hospital in setting up its disaster plan. It incorporates features which have proved effective in civilian casualty situations.

1. Alert is received from the local civil defense authority stating the extent of disaster, probable demands on the local hospital, number of patients, type of injuries, method of transport, and estimated time of arrival.

2. Alert and activate hospital personnel at the time of disaster by using the community central alerting system (sirens, factory whistles) and supplement with telephone, radio, or messenger contact as necessary.

The determination of the most effective method of alerting personnel, both employee and volunteer, will depend upon the relative geographical location of homes and places of work, the time of day, and the day of the week.

Acquired personnel in addition to regular hospital employees must be obtained by prearrangement with the local civil defense organization, American Red Cross, Visiting Nurses Association,

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[1]Assistant superintendent of the State of Wisconsin General Hospital, and a member of the committee on civil defense of the Wisconsin Hospital Association.

[2]President, the Wisconsin Hospital Association.

[3]Chairman, the committee on civil defense of the Wisconsin Hospital Association.

and other similar groups. Proper identification cards and identification with the civil defense program in the community is a requirement for all personnel, regular or voluntary. Without such identification it may be difficult, if not impossible, to pass through police lines and other official barricades enroute to the hospital or other stations.

Telephone and address listing of all key personnel should be available at the switchboard and in the administrative offices for immediate use. Included on this list should be those persons responsible for the operation of all departments and services of the hospital.

Upon arrival at the hospital, all alerted personnel must report to prearranged assembly points. In addition, key personnel should check in with the switchboard operator.

Provision should be made for a line of authority of key personnel so that there will be no interruption of administrative control in the absence of the administrator or his assistants. Under the line of authority schedule, specific assignments should be filed with the State Office of Civil Defense for the evacuation department and control in each of the subsidiary or auxiliary facilities which would be a part of the total hospital disaster plan.

Services

1. *Beds, Cots, and Bedding*—Prearranged plans for the availability of cots or beds, bedding, and all essential bedside equipment must be put into effect as a part of the total local civil defense program. These items must be set up in the hospital, and in the auxiliary, receiving, or evacuation buildings and must be in readiness at the time disaster casualties arrive. When and as this equipment is made available through civil defense organization, arrangements should be made with local authorities to provide for the storage of these items in the buildings in which they are to be used or as close thereto as possible.

2. *Emergency Kits*—Cabinets, boxes, or lockers outfitted with emergency drugs, dressings, surgical instruments, and supplies must be distributed to all areas providing improvised care. This will apply both to the hospital building and to all auxiliary buildings.

3. *Blood, Plasma, and Intravenous Solutions*—Shock and loss of blood will have top priority in the care of disaster patients, and adequate provisions must be made for necessary supplies. It must be assumed that the normal sources of supply in most cases will be impaired or cut off. Therefore, alternate sources must be developed in advance.

The American Red Cross chapter serving your local community should be incorporated in your local disaster planning. In addition, each hospital should have supplementary bleeding programs to assist in meeting the emergency requirements.

4. *Pharmacy*—As a part of the total emergency need, it is essential that the pharmacy be staffed and open throughout the duration of the emergency.

5. *General Services*—Dietary department, housekeeping, laundry, and maintenance departments are equally important in a disaster emergency and must be staffed continuously through the emergency.

6. *Supplies*—It will be the responsibility of the individual hospital through its normal sources or through the civilian defense organization to see that it is adequately equipped to handle the additional demand on its supplies, food, medication, dressings, and so forth. In a declared emergency, any such ncessary acquisition or purchase of supplies will be reimbursed by the state of Wisconsin.

Handling of Patients

1. *The Admission*—The admission procedure will of necessity have to be at the point of entry to the hospital. Provision must be made for tagging, registering, and receipt and custody of personal valuables. Final screening of the patient will occur at this point before he is sent to the specific area in the hospital or any auxiliary building for treatment, and a continuous accurate check on available beds as related to demand should be made. The admitting officer of the hospital is usually the best qualified for this job. The medical screening team shall determine the priority of admission of the casualties in the hospital. The admitting officer shall admit patients according to priority to the limit of the beds available.

2. *Segregation of Cases*—Segregation of cases with like injuries or treatment problems is highly desirable: for example, burns to a burn ward, trauma to an orthopedic ward, general surgery to a surgical ward, shock cases to a medical ward, and radiation sickness to a medical ward. Such segregation wherever possible will facilitate treatment and will simplify the work load.

3. *Physicians' Services*—Through existing medical staff organization, assignment of the members of the medical staff will be made to areas in the hospital. Under such arrangements, of course, no patient will have a personal physician.

4. *Continuous Evacuation*—To relieve over-crowding, patients will be evacuated according to their need or ability to take care of themselves, to their homes, to auxiliary or secondary hospitals in the community, to other hospitals outside of the community where special care is available, or to hospitals farther removed from the disaster area where the patient may continue his convalescence.

5. *Press Releases, Visitors, and General Public*—Adequate control provisions should be made for the reporting of casualty lists to the press and members of families of injured persons, as well as

provisions for the exclusion from the hospital building proper of all persons not under care or serving the injured.

Cooperation With Civil Defense Authorities

Liaison will be continually maintained between the local hospital and its auxiliary facilities, with the local civil defense organization, an area organization, or the state as the case may be. Although the hospital and its organization have a special type of service to render in a disaster emergency, they must of necessity call upon other elements of civil defense organization, local, state, and national, from time to time as the hospital completes portions of its responsibility. Local hospitals should recognize their responsibility to call upon the civil defense organization for help in unmet needs, to report conflicting requests if they should occur, and to give help to the civilian defense organizations as it is indicated.

The suggested plan above can be adapted to hospitals in all communities regardless of size and location. It should, however, be understood that local conditions will somewhat alter the plans. It would not be possible to have an exact diagram of organizational structure which could be used by all hospitals. The broad concepts of the plan, however, should be sufficiently detailed to cover the specific items outlined.

SCHEDULE OF PROGRAMS OF THE "MARCH OF MEDICINE"

On April 1, 1952, the March of Medicine began its seventh consecutive year of radio broadcasting. The programs, which are tape recorded, feature Dr. R. C. Parkin discussing various health problems with a lay person who is called "Your Medical Reporter." At present 33 stations in Wisconsin, one in Michigan, and one in Minnesota are cooperating in presenting this program as a public service feature. The most recent schedule is as follows:

Station	*City*	*Time*	
WHBY	Appleton	Saturday	8:30 a.m.
WBEV	Beaver Dam	Saturday	9:30 a.m.
*WHKW	Chilton	Saturday	10:30 a.m.
*WHWC	Colfax	Saturday	10:30 a.m.
*WHAD	Delafield	Saturday	10:30 a.m.
WEAU	Eau Claire	Saturday	1:30 p.m.
KFIZ	Fond du Lac	Saturday	8:15 a.m.
WBAY	Green Bay	Saturday	9:00 a.m.
*WHLA	Holmen	Saturday	10:30 a.m.
WJMS	Ironwood, Michigan	Saturday	8:15 a.m.
WCLO	Janesville	Saturday	6:35 p.m.
WLIP	Kenosha	Saturday	11:15 a.m.
WKBH	La Crosse	Saturday	11:00 a.m.
WLDY	Ladysmith	Saturday	10:15 a.m.
*WHA	Madison	Saturday	10:30 a.m.
WIBA	Madison	Saturday	9:00 a.m.
WOMT	Manitowoc	Saturday	10:15 a.m.
WMAM	Marinette	Saturday	2:30 p.m.
WDLB	Marshfield	Saturday	8:45 a.m.
WIGM	Medford	Saturday	11:30 a.m.
WEMP	Milwaukee	Sunday	1:00 p.m.
WEKZ	Monroe	Friday	2:00 p.m.
WNAM	Neenah	Wednesday	8:30 a.m.
WOSH	Oshkosh	Saturday	9:45 a.m.
WIBU	Poynette	Thursday	2:30 p.m.
KAAA	Red Wing, Minnesota	Monday	9:15 a.m.
WOBT	Rhinelander	Saturday	8:30 a.m.
*WHRM	Rib Mountain	Saturday	10:30 a.m.
WJMC	Rice Lake	Saturday	10:30 a.m.
WRCO	Richland Center	Wednesday	10:00 a.m.
WHBL	Sheboygan	Sunday	1:00 p.m.
*WLBL	Stevens Point	Saturday	10:30 a.m.
WDOR	Sturgeon Bay	Thursday	9:15 a.m.
WDSM	Superior	Sunday	10:00 a.m.
WSAU	Wausau	Monday	4:45 p.m.

* These stations also carry programs at 7:00 p.m. on Wednesdays on FM only.

Medical Supplies for Mobile Medical Teams Under State Civil Defense

By E. H. JORRIS, M. D.
Assistant Co-Director, Health Services Division, Wisconsin Civil Defense
Madison

THE process of organizing mobile medical teams to operate as integral units of area mobile battalions under the State Director of Civil Defense has been under way since the winter of 1950. As had been anticipated, it has been a slow and somewhat discouraging procedure. A general feeling of apathy and unreality has been difficult to overcome. For the most part physicians have been very cooperative and have volunteered and given generously of their time in making the plan a success. Selected leaders among the members of the State Medical Society on the Medical Advisory Committee have worked unstintingly to bring the plan to fruition. Definite progress can be reported in many aspects of the plan, including organization, training, integration, and the procurement of equipment and supplies.

From the start it has been obvious to many that a medical team without adequate equipment and supplies would be most seriously handicapped in caring for the injured, yet no definite assurance could be given at that time that the supplies and equipment would be forthcoming. Team captains were asked to proceed with the organization of their team on faith. The State, represented by its Governor, and the other members of the Emergency Board, when approached with the problem in March of 1952 recognized the responsibility for the protection of the citizens of Wisconsin from the threat of disaster and made an allotment for medical supplies and equipment. This allotment was for $102,253.50 of which $83,853.50 will be matched with an equal amount by federal funds, making available a total of $186,107 for medical supplies and equipment. About $100,000 of this total was earmarked for plasma. Litters and litter cots are provided for under a separate legislative appropriation. On the basis of 100 teams there is thus available an amount equal to $1,861.00 per team, exclusive of litters and litter-cots.

The Medical Advisory Committee of the State Medical Society has worked out a standard list of equipment and supplies for each team which it believes will be adequate to supply the team until supplementary supplies can be secured from federal stockpiles. This list is essentially the same as that carried on page 57 of the Manual, "Health Services and Special Weapons Defense," with some minor modifications and additions. It is anticipated that the supplies will be packaged for easy mobility with a list of the contents attached to avoid the necessity of opening each package for inspection. Final arrangement for storage of the supplies will be complete before they are delivered. Some delay in procurement is anticipated. It is planned that packaging of the items for each team will be arranged commercially in order to put into effect a uniform method for protecting these supplies. With the likelihood that some items will be available before others, final packaging must of necessity await delivery of all items.

Arrangements are being made to avoid outdating of antibiotics through the use of a central inventory control. Special arrangements are under way for the procurement and storage of liquid plasma under a contract where a continuous exchange of the plasma can be effected in order to insure a fresh supply.

The Medical Advisory Committee recommends that supplies for training purposes be obtained locally using improvised bandages, splints, etc., so as to do the whole job as economically as possible. Throughout, there has been very careful scrutiny of all expenditures, to keep them to minimum essentials in the interest of economy.

There is still much to be done, many details to be settled, and of course everyone working on the problems is already busy with a full time job of his own. Despite all obstacles, definite progress is being made. We are beginning to see some light.

In the meantime, if your medical team is organized and trained, you as a representative of the medical profession will have done everything within your power to prepare for an atomic disaster.

The Diabetic and the Atomic Bomb*

The following information might be given to all of your diabetic patients:

Read the government's small pamphlet called "Survival Under Atomic Attack." Get it from your Civil Defense organization. Read it!

Carry your diabetic identification card with you at all times. If you have not yet secured one, your doctor can get one for you.

WHERE TO GO

In the event of an atomic bomb attack on your city, the chance of you and your home escaping injury is very good. If, however, you are within the destructive range of the bomb, you could either be injured or uninjured, but your home would probably be partially or entirely destroyed. If you are injured, you will be cared for and your diabetic condition will have attention—rest assured of that. If you are homeless and you have friends who will care for you, you need not worry.

Prepare to take care of yourself completely if you are uninjured. Your family and friends should be taught enough about diabetes to take care of you in an emergency.

INSULIN

Every diabetic should know how to take insulin. There is plenty of insulin. Every diabetic taking insulin should have his usual *one extra bottle* in addition to current needs and *one extra insulin syringe* with two needles. This is because insulin is your best friend and with it you have the best possible insurance.

Always use your oldest bottle first. For emergency purposes regular insulin is superior to the other forms. Carry a little case with your insulin syringe, if you have one.

If an emergency arises and you must change from long-acting insulin (protamine zinc insulin, globin insulin, or NPH insulin) to regular insulin, take 2 doses of the regular; for the morning dose take 3/5 of the number of units of your usual dose of the long-acting insulin, and for the evening dose take 2/5.

If you have no food, reduce your dose to 1/2 or 1/3 of these amounts to avoid insulin reactions. Test your urine.

EMERGENCY DIET

Keep to your diet as nearly as possible in all circumstances. It is better to eat too little than too much. Here is a simple emergency diet one can get under most any circumstances:

Breakfast	Noon and Night
Bread, 2 or 3 slices	Meat or cheese sandwich or
Butter or margarine	Bread and butter alone, 3 slices, or
Coffee and canned milk or	Meat and potatoes, with such
In place of bread, a cereal and a can of milk	vegetables as are available (stew)

You can get along on this simple fare for several days, if necessary.

For further information for the diabetic patient, the article "The Diabetic and Civilian Defense," Statement by the Committee on Emergency Medical Care and the American Diabetes Association, which was published in the Dec. 1, 1951 issue of the *Journal of the American Medical Association*, is recommended.

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*Excerpted from DIABETES, January 1952 issue, page 81.

Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

Plasma Substitutes

Investigators have laid down the following theoretical requirements of a plasma substitute: (1) It should not pass readily into the tissue fluids or be rapidly excreted by the kidney (molecular weight of at least 70,000, that of serum albumin, is usually desirable) and should not be rapidly metabolized or otherwise removed by the tissues. (2) The solution should exert osmotic pressure and have a viscosity similar to plasma. (3) Its composition should be practically constant, and it should be stable during storage at room temperature. (4) It must not be toxic, not induce fever or sensitization, not be stored for long periods in the tissues, and not act as a diuretic. Since there is satisfaction as yet with none of the substitutes, I shall be brief.

Gelatin derived from beef bone, and commercially available as Specialized Gelatin Solution, Intravenous 6 per cent, containing 60 mg. of gelatin per cubic centimeter, is given at the rate of 30 cc. per minute, usually in infusions of 500 cc. It is said that about 50 per cent of the gelatin remains in the circulation for 24 hours, presumably exerting its osmotic effect to hold fluid during all of that time. Renal damage, which may exist in extensive third degree burns, lessens excretion and probably contraindicates the use of gelatin. Gelatin is nonantigenic, but it may interfere with blood typing and crossmatching. It is a gel at room temperature and must be warmed before use, a consideration that practically precludes its use in outdoor emergencies.

Dextran, developed in Sweden and so far used principally there and in Britain, is a polysaccharide product of microbial action on sucrose. As used in Britain, it is freed from protein and the range of its molecular weight is controlled, I believe between 80,000 and 100,000, to decrease loss of the smaller particles into the urine. The theoretical advantages of dextran over other nonprotein colloids are as follows: (1) It is free from acidic radicals and therefore not likely to form storage complexes; and (2) it can be hydrolyzed into glucose by acids and certain living organisms, which suggests that the human body may also be able to metabolize it slowly.

In rabbits rapidly deprived of about half their estimated blood volume by bleeding, intravenous infusion of an equivalent amount of dextran has been found to restore blood pressure more rapidly than whole blood or saline and to maintain it for 3 to 3½ hours in some experimental studies. It appears that about 25 per cent of injected dextran escapes into the urine soon after infusion and that some of it does pass into the tissues, but on the whole it is well retained in the circulation, according to recent British studies. It seems to disappear gradually from the body, but whether its disappearance is complete could not be definitely determined in these studies. It might be slowly metabolized as glucose; or it might be slowly broken down to a molecular weight less than 70,000 and excreted by the kidneys; or part of it might be excreted after suitable degradation, the remainder being burned as glucose.

In clinical trials, dextran has been used in 6 per cent solution in saline in amounts of 200 to 500 cc., run in during 2 to 7 minutes.

In mice, guinea pigs, and rabbits given dextran, no evidences of toxicity, pyrogenicity, antigenicity, or tissue damage have apparently been found. Dextran, however, does cause rouleaux formation of the erythrocytes and hence would interfere with direct blood-matching tests. It also increases the erythrocyte sedimentation rate. Acute parenchymatous toxicity has not been reported, but in a recent study, 10 of 30 volunteers had reactions of either anaphylactic or anaphylactoid nature that were believed to be specifically related to the molecular structure of the dextran molecule and its concentration in the plasma. Necropsy studies on 6 dogs given large quantities of the agent revealed focal degenerative lesions in the liver and kidneys and minimal reticuloendothelial hyperplasia in the spleen; but nothing abnormal was found with regard to urine, liver, spleen, lymph nodes, blood pressure, hemoglobin percentage, serum bilirubin, or serum protein level in a small group of patients re-examined some months after receiving therapeutic dosage.

Pectin, a colloid of wide occurrence in plants, is employed, after suitable treatment to reduce the range of molecular weights, in concentration of 1.0 to 1.5 per cent in buffered physiologic saline. Less than half the administrated pectin is excreted in the urine of experimental animals, the remainder being stored, principally in the spleen. The ultimate fate of the compound is unknown, but some is still identifiable in the tissues up to three months. The erythrocyte sedimentation rate is increased for 24 hours and the platelets reduced. Purpuric rashes have occurred on rare occasions.

Polyvinyl pyrrolidone (PVP). This synthetic compound, derived from acetylene and related to some of the plastics, is being intensively studied in research hospitals but is not yet released for general use. In the trials it is being used in a 3.5 per cent aqueous solution that also contains 0.65 per cent sodium chloride, 0.042 per cent potassium chloride, 0.025 per cent calcium chloride, 0.0005 per cent

magnesium chloride, and 0.024 per cent sodium bicarbonate. The preparation appears to have physical properties quite similar to those of plasma, and it seems that in most instances its plasma substituting action persists for at least 12 hours. Practically no toxicity has so far been reported, but the complete metabolic fate of the compound is unknown, as is also the extent of its effect upon and storage in the reticuloendothelial system. The erythrocyte sedimentation rate is increased, but the typing or crossmatching of blood are not altered. About 20 per cent of PVP appears in the urine within 3 days; traces are still detectable after three weeks.

Acacia and methylcellulose have been practically abandoned because of considerable and possibly harmful storage in the liver.—HARRY BECKMAN, M. D.

CONVENTION ON REHABILITATION TO BE HELD IN MILWAUKEE, JULY 7–12

The Association for Physical and Mental Rehabilitation will hold its sixth annual convention in Milwaukee at the Hotel Schroeder from July 7 through July 12. The general assembly of the convention will not begin until July 8, when the Very Reverend E. J. O'Connell, S. J., president of Marquette University, will give the invocation, and welcoming speeches will be presented by the Honorable Frank P. Zeidler, mayor of Milwaukee; Dr. A. H. Heidner, president of the State Medical Society; Dr. N. J. Wegmann, president of the Medical Society of Milwaukee County; and Mr. D. C. Firmin of the Veterans Administration, Wood. Dr. J. C. Griffith, president-elect of the State Medical Society, will speak on "The Importance of Physical Medicine and Rehabilitation to the Medical Profession."

The scientific program will be a series of panel discussions with a large number of well known speakers. The schedule is as follows:

Tuesday, July 8

General Chairman: Harold C. Lueth, M. D., Dean, School of Medicine, University of Nebraska.
9:45 "Basic Concepts of Rehabilitation"
General Chairman: J. F. Sheehan, M. D., Dean, School of Medicine, Loyola University.
1:00 "Psychological Theory and Technique as Related to Rehabilitation"
3:15 "Rehabilitation of Hospitalized Mental Patients"
General Chairman: J. S. Hirschboeck, M. D., Dean, School of Medicine, Marquette University.
8:00 "Employment of the Medically Handicapped"

Wednesday, July 9

General Chairman: Richard H. Young, M. D., Dean, School of Medicine, Northwestern University.
9:00 "Current Techniques in Rehabilitation of Paraplegic Patients"
11:00 "Rehabilitation of the Speech Impaired"
1:00 "Today's Approach to the Care and Treatment of the Geriatric Patient"
3:45 "Teamwork on a Rehabilitation Ward"

Thursday, July 10

General Chairman: L. T. Coggeshall, M. D., Dean, School of Medicine, University of Chicago.
9:00 "Educational Standards for Rehabilitation Personnel"
General Chairman: J. D. Van Nuys, M. D., Dean, School of Medicine, University of Indiana.
1:00 "New Horizons of Corrective Therapy"

Friday, July 11

General Chairman: A. C. Furstenberg, M. D., Dean, School of Medicine, University of Michigan.
9:00 "Rehabilitation of the Amputee"
General Chairman: S. W. Olson, M. D., Dean, School of Medicine, University of Illinois.
1:00 "Orientation of the Blind"
3:15 "Daily Care Activities in Medical Rehabilitation"

Saturday, July 12

General Chairman: J. M. Kinsman, M. D., Dean, School of Medicine, University of Louisville.
9:00 "Employment of the Physically Handicapped"

Clinicopathologic Conference

Editors—W. A. D. ANDERSON, M. A., M. D., Marquette University School of Medicine, Milwaukee and D. M. ANGEVINE, M. D., University of Wisconsin Medical School, Madison

PRESENTATION OF CASE*

Dr. A. M. Kohn: The patient, a 54 year old white woman, was first seen at her home one week prior to her entrance into the hospital. At that time she complained of nausea, burning abdominal pain, diarrhea and occasional vomiting. She gave the history of having seen several physicians who diagnosed her case as a menopausal syndrome. One of them had x-rayed her chest and stomach and did an electrocardiogram. The one positive finding at this examination was mild pitting edema (1 plus) of the left leg and moderate tachycardia (100) with occasional extrasystoles. She was advised to come to the office for more complete examination. The nature and extent of her complaints were certainly suggestive of a menopausal syndrome but with other conditions to be considered pending more complete examination.

Her examination at the physician's office revealed no new findings, and the ankle edema had disappeared. Funduscopic, pelvic, and rectal examination added no new information, and neurologic examination was negative. Urinalysis, however, revealed a four plus albumin, and a blood nonprotein nitrogen and creatinine taken at that time was reported as 90.0 and 4.5 mg. per cent respectively. The gastrointestinal complaints continued and, because of the very obvious seriousness of her condition, she was hospitalized for more diagnostic work and treated for her uremia.

She was admitted to the hospital on Sept. 18, 1950. The admission complaints were weakness and pain in both legs. The illness dated back to April 1950, when she noticed increasing weakness, which persisted. She had lost approximately 30 pounds weight and had loss of appetite.

Previous illness included only measles. Menstrual history was negative; one pregnancy. Systemic review was negative except for present complaints.

On physical examination she appeared to be a well developed, fairly well nourished, white female. The blood pressure was 110/58 mm. of mercury, pulse 80, and respirations 20. The head and neck were negative. No palpable masses were felt in the neck. The lungs were clear to percussion and auscultation; expansion was equal. The heart rate and rhythm were regular. No cardiac enlargement was noted. The abdomen was soft and non-tender, with no palpable masses or viscera. There was slight swelling of the feet and ankles.

Laboratory—Laboratory data included: Erythrocytes 4,590,000; hemoglobin 12.5 Gm. or 81 per cent; color index 0.9 minus; leukocytes 16,650; stabs 4 per cent; segmented 81 per cent; lymphocytes 15 per cent. Protein was 6.72 Gm.; albumin 4.24 Gm.; globulin 2.48 Gm.; and albumin–globulin ratio 1.7/1.0. Blood culture was negative. The urine showed on three separate occasions a specific gravity of 1.005 to 1.006. There was 2 to 4 plus albumin, and occasional epithelial cells and white blood cells. The sedimentation rate was 69 mm. in 1 hour, 106 mm. in 2 hours. A blood nonprotein nitrogen was 95.2 mg. on admission, reaching 133.3 mg. within two weeks. Creatinine was 4.2 mg. on Sept. 19, 1950, reaching 7.4 mg. on Sept. 26, 1950. Carbon dioxide-combining power was 44.8 volumes per cent on Sept. 19, 1950. A urine concentration test showed urine specific gravity to range from 1.005 to 1.007; urine dilution ranged from 1.004 to 1.010. Urea clearance revealed 16.2 cc. of blood cleared per minute, or 21 per cent of normal in the first hour, and 2.89 cc. or 5 per cent in the second hour.

Various cancer detection or diagnostic tests were done with the following results: Huggins–Jensen, 3 plus; methylene blue reduction, 2 plus; brilliant cresyl blue, 4 plus; Kopaczewski, 4 plus; and heat coagulation, 3 plus.

Roentgenograms showed a solitary gallstone, and normal colon and ileum. Electrocardiographic studies revealed coronary insufficiency with heart strain and ectopic auricular impulses.

Urinary output during the entire stay in the hospital varied from 500 to 1,200 cc. in spite of forced intake which varied from 1,500 to 3,000 cc. The patient's temperature varied from 97 to 98 F., being usually subnormal. Pulse rate varied from 60 to 84 and respirations from 16 to 24 per minute. The patient's course was progressively worse. On Sept. 30, 1950, cutaneous rash was noted over her body, most marked about the knees and elbows. It was accompanied by burning and itching. On Oct. 2, 1950, the patient began vomiting which became a daily feature. The pain in the legs became intense. On Oct. 4, 1950 the patient became confused, restless, and noisy. The skin on Oct. 7, 1950 was described as dry and scaly. On October 10, she became incontinent, and hiccoughs were noted. On October 12 she became comatose, and edema of the hands was present. She expired on Oct. 14, 1950.

Treatment had included forced fluids by mouth and veins, local therapy to skin lesions, barbiturates

*From St. Joseph's Hospital, Milwaukee; **Dr. A. M. Kohn** and **Dr. B. J. Peters**, clinicians; **Dr. G. W. Sengpiel**, radiologist; and **Dr. W. A. D. Anderson**, pathologist.

for sedation, salt-free diet, and demerol. Beginning on Oct. 10, 1950, she had received 10 mg. of ACTH four times a day.

Dr. G. W. Sengpiel: On Sept. 25, 1950 a survey film of the kidney, ureter, and bladder tract revealed rather marked distention of numerous loops of small bowel arranged in parallel. There also appeared to be some gas in the transverse colon, but a partial small bowel obstruction was not excluded. A solitary calcified gallstone one and a half centimeters in diameter was seen in the right upper quadrant. Both kidneys were generous in size, but there was no evidence of a calculus overlying the urinary tract.

On Sept. 26, 1950, a barium enema revealed a normal large bowel and distal ileum with no evidence of obstruction in the colon or the distal 18 inches of the ileum. There was much less gas in the small intestine, and it was felt that the distention of the small bowel was on the basis of an adynamic ileus rather than a mechanical obstruction.

Dr. B. J. Peters: In reviewing the protocol, one notes that this patient entered with complaints of weakness, pain in her legs, and a weight loss of approximately 30 pounds. The history as outlined is not diagnostic of any special illness, as it is common to many debilitating diseases. When confronted with a problem such as this, one has to examine the patient very carefully and attempt to uncover a clue that may help in arriving at a diagnosis. As we read through the record of the physical examination we note no findings that are helpful in arriving at a final diagnosis. The slight swelling of the ankles is the only positive finding. The blood pressure is perfectly normal at 110/58.

Being confronted with this type of problem, one has to turn to the laboratory for help. In checking the laboratory tests we find that the most significant findings are in the urine examination. The urine contained albumin of 2 to 4 plus on several occasions and a specific gravity which was fixed at 1.005 and 1.006. The next important laboratory finding was the nonprotein nitrogen at a level of 95.2 mg. per cent which gradually rose to 133 mg. per cent. The urine examination and the finding of an elevated nonprotein nitrogen finally put one on the trail of where to look for the disease process. Because of these findings, renal function tests were done. The urea clearance in this patient was 16.2 cc. of blood cleared per minute. The normal is 75 cc. of blood cleared per minute. The other function test also demonstrated marked renal dysfunction. The concentration test showed a range between 1.005 and 1.007, pointing to marked tubular dysfunction.

To recapitulate, we have a patient whose history and physical examination is of no value, but in whom the presence of a renal disease is demonstrated by the urinary findings and also the presence of azotemia as revealed by the elevated nonprotein nitrogen. We find that this patient showed evidence of marked renal dysfunction, as shown by the abnormal urea clearance test and abnormal concentration test. These, however, do not tell us the exact diagnosis. If we review this patient's course in the hospital, we find that as time progressed she developed uremia and demonstrated the various symptoms that one sees in this syndrome. It is noted that a cutaneous rash appeared over her knees, elbows, and some over the body. Skin manifestations are not unusual in patients with advanced renal disease. This may be due to the excretion of the urates through the skin, or it may be due to the medications these patients receive which normally would be excreted through the kidneys but instead, when renal impairment is severe, are excreted through the skin thereby producing a skin irritation.

The next symptoms that appear are those involving the central nervous system. We note the patient became depressed and then became drowsy, and finally lapsed into coma. The depression so common in uremia is probably due to the retention of the phenol products. In uremia, large muscle group twitchings occur. This undoubtedly is due to a decrease in the ionizable calcium. The calcium depression is due to the retention of phosphates and oxalates and probably due to the retention of potassium and guanidine, these latter substances being antagonists to calcium. Likewise, in a disease in which there is considerable excretion of albumin, protein bound calcium may be reduced and muscular twitching or frank tetany may result. Later, respiratory symptoms developed in this patient. In the older individual in uremia, Cheyne–Stokes respiration is not uncommon. In those with central nervous system irritation due to increased intercranial pressure, stertorous type of respiration may be present. In those with retention of the inorganic acids, Kussmaul respiration is common. The other symptoms in uremia are those referable to the vascular system. The most common condition is a pericarditis which results from the deposition of the urates on the pericardium. No mention of that is made in this patient. Gastrointestinal symptoms make their appearance as in this patient; she had vomiting and diarrhea. In fact, some may develop gastrointestinal hemorrhage and enter the hospital with hematemesis or melena, and a diagnosis of carcinoma may be entertained. A difficult problem may present itself in patients who have had massive hemorrhage from a bleeding ulcer, and then develop an increase in the nonprotein nitrogen. One then must determine whether the nonprotein nitrogen rise is due to primary renal disease or is secondary to the bleeding and renal shutdown from the resulting shock. If urinary abnormalities are present or history of previous nephritis is obtained, the diagnosis then becomes obvious. In this patient the diagnosis has not as yet become obvious. All we can say is that we have a 54 year old white female who has evidence of a renal disease, with a blood pressure which is perfectly normal, and in whom during her clinical

course uremia developed. I feel the best approach to this problem is from the causes of uremia. We can put them into two main groups. First, there are those with renal disease and associated hypertension which progresses into uremia, and secondly, those with renal disease without hypertension and in uremia. The common renal diseases with hypertension and uremia are acute glomerulonephritis, chronic glomerulonephritis, benign and malignant nephrosclerosis, polycystic kidney, unilateral pyelonephritis, and periarteritis nodosa.

Is it possible that this patient had any of these diseases? I do not feel we are dealing with acute nephritis. If we check the findings of the urinary sediment, we note that there were no red blood cells and no casts. We also note that there was a low fixed specific gravity. In acute nephritis, the specific gravity is usually much higher, ranging from 1.024 to 1.030. Hematuria, microscopic or gross, is always present. I think chronic glomerulonephritis may be ruled out, even though the specific gravity of the urine is fixed, for in chronic glomerulonephritis the urinary sediment contains red blood cells or casts. Also, it is rare to have advanced chronic glomerulonephritis with uremia and without hypertension. Nephrosclerosis, benign or malignant, may likewise be ruled out as this patient lacks the hypertension. In nephrosclerosis the specific gravity of the urine is not as low as in this case. In benign nephrosclerosis there is a reduction of the specific gravity of the urine to 1.015 or 1.020. There is one to two plus albumin, and occasionally a few red blood cells. In malignant hypertension, with its necrotizing arteriolitis, there is more marked hematuria, vascular changes in the eye grounds appear, and rapid, progressive uremia is frequent. The lack of hypertension and urinary findings rules out the presence of malignant and benign nephrosclerosis.

On x-ray examination we find that this patient had large kidneys, and it is possible that she may have had polycystic kidneys. However, patients with polycystic kidneys eventually have a marked hypertension, and the urine findings are much different than in this patient.

Periarteritis nodosa is likewise associated with hypertension, and a urine picture not unlike that in acute nephritis. This patient does not fulfill these requirements. Since we cannot include this patient in the previous category, namely, kidney disease with hypertension and uremia, let us see if she can be included in our second category, the group with uremia in a patient with renal disease without hypertension. The first to be considered is bilateral cortical necrosis of the kidneys. This is seen in women following a toxemia of pregnancy in whom uremia develops but not necessarily hypertension. Since there is no history of toxemia of pregnancy, I do not feel that this diagnosis should be considered.

The next condition that may be associated with uremia without hypertension is mercury bichloride poisoning. There is no history of its ingestion so we can rule out this as the cause of the uremia. The next condition to be considered is renal tuberculosis. In renal tuberculosis, there is hematuria, pyuria, and variable degrees of proteinuria. This patient lacks the hematuria and lacks the history of having had previous tuberculosis; therefore, we can rule out tuberculosis. We then come to the final two possibilities in this group, namely, amyloidosis and pyelonephritis. As you know, in amyloidosis there is usually a history of a chronic suppurating infection such as osteomyelitis, lung abscess, empyema of the lung, rheumatoid arthritis, pulmonary tuberculosis, or syphilis. It is characterized by the presence of marked edema, marked proteinuria, with very few, if any, formed elements in the urine. Later there is an albumin-globulin reversal in the plasma with an increase in the blood cholesterol. This patient had no history of chronic infection, showed no albumin-globulin reversal, and had relatively little edema. A diagnosis of amyloidosis, therefore, seems less likely. In view of this fact, we are left with only one probability and that is a chronic pyelonephritis. First, the patient was a woman, and they are subject to bladder infections more readily than men, as a result of this an ascending pyelonephritis may develop. Secondly, the generous kidney size may be present, especially during exacerbations of a chronic infection of the kidneys. Thirdly, we have the presence of a moderate amount of albumin and

Fig. 1.—Left kidney, showing smooth pale external surface, and tumor mass.

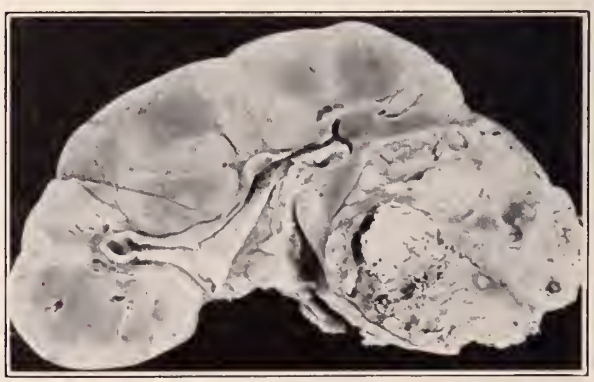

Fig. 2.—Left kidney, showing encapsulated tumor (hypernephroma) with areas of necrosis. The renal tissue is pale, and without gross scarring or contraction.

white blood cells in the urine, followed by uremia without hypertension. These findings justify the diagnosis of chronic pyelonephritis as the most likely cause of this patient's uremia and subsequent death.

Dr. W. A. D. Anderson: Autopsy examination showed the most striking findings in the kidneys. The left kidney weighed 460 Gm. The surface was smooth and pale, with a few small petechiae. In the upper pole of the kidney there was an encapsulated tumor which measured 8 cm. in diameter. The external surface of the tumor was reddish-purple and traversed by dilated vessels. The cut surface of the tumor appeared nodular and multicolored, with focal areas of red, yellow, and orange shades. The parenchyma of the kidney appeared swollen and

Fig. 3.—Kidney, showing amyloid deposits in glomeruli and tubular casts.

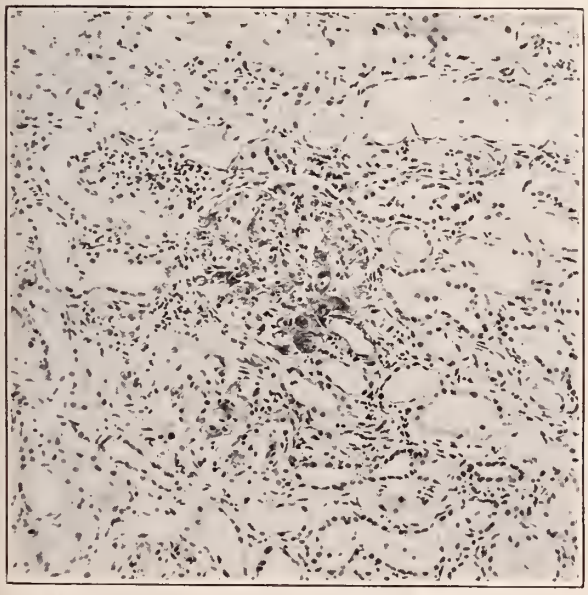

Fig. 4.—Kidney, showing amyloid in glomeruli and afferent arteriole.

Fig. 5.—Amyloid masses in spleen, and a multinucleated giant cell.

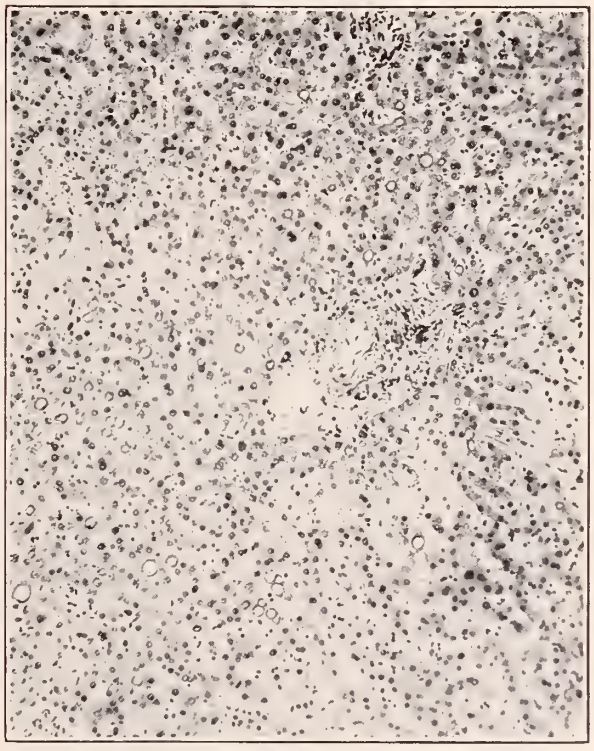

Fig. 6.—Amyloid deposits between cords of liver cells.

pale on the cut surface. A few petechial hemorrhages were seen on the pelvic mucosa and over the calyces. The right kidney weighed 280 Gm., and it likewise had a smooth external surface and appeared swollen and pale.

Other gross changes were not prominent. The heart weighed 360 Gm., and the myocardium appeared rather pale with some small yellowish flecks. The lower lobe of the left lung contained some patchy consolidation, and the overlying pleura showed some fibrinous exudate. The left pleural cavity contained about 200 cc. of fluid. The gallbladder contained a single calculus 1.2 cm. in diameter. The cut surface of the liver and spleen, both of which were firm, showed some small pale translucent areas. Other organs were without important gross changes.

Microscopic examination revealed the specific nature of the condition. In the kidneys there was a fairly severe diffuse deposit of amyloid in the glomeruli and the walls of small arteries and arterioles, and a similar but lesser degree of amyloid deposition was present as focal masses in the spleen, separating cords of liver cells, and in blood vessels in the lung. The amyloid material stained prominently with Congo red. There were occasional multinucleated giant cells evident about amyloid deposits in the spleen and kidneys. Renal tubules also showed hyaline degeneration. The involvement of the kidney was severe and diffuse enough to account for the clinical features of renal disease. The renal tumor was a clear cell carcinoma (hypernephroma) which appeared to be still in a stage of encapsulation, and no vascular invasion or metastases were found. The left lung showed a terminal bronchopneumonia. The heart contained areas of inflammatory exudate, with mononuclear cells, lymphocytes, plasma cells, and occasional neutrophilic and eosinophilic leukocytes, both focally and diffusely in interstitial tissue of the myocardium. Some fibrinous exudate was present on the pericardial surface, and there was some mild hemorrhagic gastritis, both being common accompaniments of uremia.

As a preceding related condition was not evident, this appears to be one of the uncommon examples of a primary systemic amyloidosis, with severe involvement of the kidneys leading to renal functional failure and uremia. The giant cell reaction to the amyloid deposits is often seen in primary amyloidosis. The edema, fibrinous pericarditis, and hemorrhagic gastritis appear to be related to the uremia. The acute bronchopneumonia is a terminal complication. The carcinoma (hypernephroma) may have contributed to the renal functional deficiency, but probably was not otherwise an important factor. The myocarditis is unexplained and appears to be of the isolated (Fiedler's) variety.

The relationship, if any, of the amyloidosis in this case to the idiopathic myocarditis or to the renal carcinoma is speculative. In view of the tendency of myocarditis to occur in hypersensitivity reactions, and the evidence for the theory of an antigen-

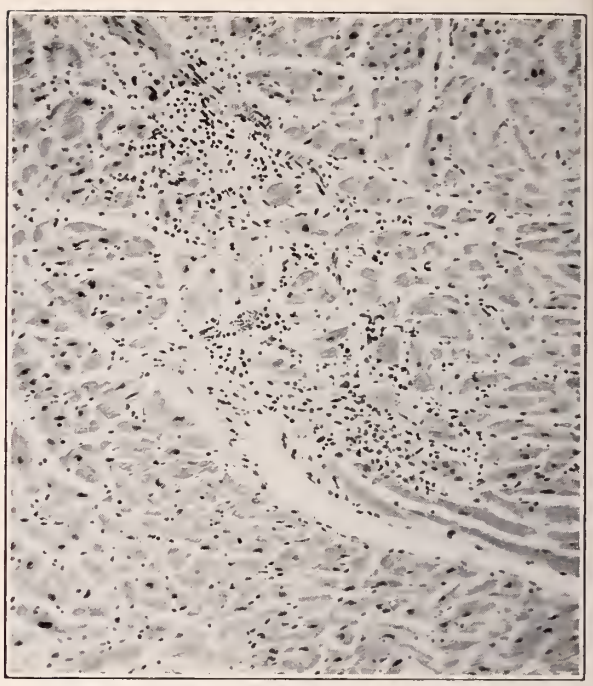

Fig. 7.—Heart, showing focal myocarditis.

antibody mechanism in the formation of amyloid,[1] one is tempted to consider that the conditions may not be unrelated. The possibility that the renal carcinoma was a primary condition leading to the development of amyloidosis appears rather unlikely in view of the infrequency of such association, and the fact that the tumor was still in a localized stage and without metastasis. Until our knowledge is more complete, it seems best to consider this as a case of primary systemic amyloidosis.

Primary or idiopathic systemic amyloidosis which is not secondary to chronic suppuration, tuberculosis, leprosy, syphilis, or other chronic destructive diseases is relatively uncommon and rarely diagnosed.[1,2] Among the slightly more than 50 cases which have been reported, many have shown a tendency to involve the heart and mesenchymal tissues, the amyloid often has been atypical in its staining reactions, and giant cell formations about the amyloid deposits sometimes have been present. In a considerable number of cases, however, the kidneys have been involved. In a few cases the renal involvement was predominant and clinically was manifested by a nephrotic syndrome. Such cases have been reported by Christian,[3] Dillon and Evans,[4] and Lindsay.[5]

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Atomic Warfare and Communicable Disease

As It Looks From the State Board of Health

THERE has been a great tendency to overlook an important aspect of civil defense planning. Such planning is directed towards measures to enable us to forestall and cope with the devastating effects of atomic and biologic warfare upon civilian population groups. We are justifiably concerned with planning for those areas which are considered prime targets for the use of such weapons, and for meeting their possible relief needs in the event of such disaster. We have, however, been inadequately concerned with facing problems which undoubtedly will be created by the shifting of large population masses from areas which are equipped to meet their needs to other locations not nearly so well equipped and with completely inadequate facilities.

The movement of such population masses need not be secondary to the advent of direct warfare in any given region; it may frequently precede such an event. As a matter of fact, this has been stated as one of the reasons to account for some of the recent great increase in suburban development near the larger cities of our country. This tendency will increase as the imminence of war increases and will reach a maximum in all sections of the country when the first atom bomb is dropped on any single given city. Contrary to frequently expressed optimistic opinions, neither education nor laws will effectively decrease such migration. This type of migration may well be greater on the whole than that brought about by the complete destruction of any one or two of our larger cities. Civil defense planning must take this possibility into consideration and adequate measures should be established. Failure to do so may result in a subsequent disease toll which may be so great that the demoralizing effect of an atom bomb "threat" will completely disrupt our industrial war-making potential and so, after the depletion of reserves, render our armed military forces useless.

Danger of Epidemic Disease

One of the great dangers of "civilization" is the tendency of its people to accept its remarkable contributions too casually, and after a short period of time to consider such contributions as a natural attribute of the very process of living. How often do we think of the role played by environmental sanitation in the conquest of epidemic disease? Students, scholars, and historians think occasionally of the epidemic scourges which but yesterday in the history of mankind threatened to wipe out the human inhabitants of an entire continent. So "ancient" seems this history in the span of a single American life, that to nearly all of us it is inconceivable that it can happen here.

It would be difficult, but not impossible, to alleviate the disastrous effect of one or more atom bombs dropped on a target city by at least partially restoring its water supply and sewage disposal facilities. In the meantime provision could be made to insure an adequate safe water supply and means of waste disposal both to former inhabitants of the stricken city and to such aid groups as may come from different areas to preplanned locations. But the problem becomes immeasurably greater when migration involving millions of persons is haphazard and unplanned. Communities with water and sewerage facilities for 5,000 may suddenly find themselves overburdened by 50,000 to 100,000 people. Problems of housing and sanitation will be overwhelming if not anticipated, and epidemic disease may return as the prime disabler and killer of mankind.

Planning for Prevention

This is not to portray a pessimistic picture any more than a description of the maximum destructive effect of an atom bomb upon a given population density would be. Realistic rather than wishful thinking will enable us to plan more accurately. Acute communicable disease has not disappeared from this country. For example, in Wisconsin alone there are now 51 known typhoid carriers; we can make no estimate of the undoubtedly much greater number of unknown carriers. Of 175 cases of typhoid and paratyphoid fever reported between 1944 and 1951, 13 were paratyphoid fever. None of us is naive enough to believe that this represents all of the cases which occurred during those years. Other enteric diseases such as bacillary and amebic dysentery must also be recognized as great potential epidemic threats. The human carrier rates for these two diseases among normal population groups in this country is relatively high. The epidemic spread of these diseases (now endemic in our population) because of inadequate hygienic and sanitation facilities, which could result from uncontrolled migration of large masses of our people, is a more likely threat than may be brought about by the introduction of "foreign" germs by an enemy.

Our supply of antibiotics with which to combat such epidemics would be very inadequate. Moreover, their use could not be considered a preventive measure. Preventive precautions through immunization are available for typhoid and paratyphoid fevers, but much remains to be accomplished before effective vaccines for bacillary dysentery become available, and there is certainly none for amebic dysen-

tery. While the enteric diseases would constitute a serious problem, we must remember that with inadequate housing and hygiene a vast group of serious endemic diseases, transmissible through contact, respiratory channels, and by animal reactors (smallpox, streptococcal disease, typhus, etc.) would become serious epidemic threats. The probable rapidity of spread and severity of illness in such event will render our medical personnel and facilities highly inadequate for the care of such vast numbers of cases. It is obvious that effective civil defense planning must be preventive in nature and must extend far beyond prime target areas. Every community not likely to become an enemy target but accessible to such an area must plan for the possibility of a sudden tenfold (or greater) increase in population, consider the adequacy of its housing, medical, and sanitation facilities in such an event, and make whatever possible provisional planning it can.

Planning for a disaster such as described cannot be effectively accomplished by untrained personnel. Both effective planning and ultimate organization and accomplishment require an adequate professional group such as is available today only in a well staffed public health unit—public health physicians, nurses, engineers, nutritionists, and other properly trained individuals. Communities with adequate full-time health departments (city, city-county, or multi-county units) will be among the fortunate in their efforts to meet such situations. Others will find themselves without a satisfactory essential branch of local government which, while not so obviously lacking under normal conditions, is indispensable in periods of real civil and military emergency.—MILTON FEIG, M. D., *Director, Section on Preventable Diseases.*

Introducing the Guest Editorialist

Major General Ralph J. Olson has served as civil defense director for Wisconsin since September 1, 1950, and as Adjutant General of the state since October 1, 1950.

It was his ambition to become a physician and surgeon and his college training was directed to that end. He earned his B.A. in Science at Ripon College, completing many pre-medical subjects. Unfortunately, circumstances made it impossible for him to go on to medical school. His background of science and deep-seated interest in the medical profession have served him well in planning the over-all civil defense program of Wisconsin, through which the importance of the medical profession has been emphasized.

Under his direction, civil defense has come to life in Wisconsin. By radio, press, and personal appearances he is bringing the necessity for civil defense planning into sharp focus in every community in the state.

General Olson believes in meeting the issues of civil defense head-on. He recognizes the inability of federal-level civil defense agencies to move rapidly in the provision of large quantities of medical supplies and equipment for stockpiling at this time, but is not willing to accept this as an excuse for unpreparedness at the local level. He believes in the marshalling of local medical supplies to meet local emergencies, and his practical suggestions for training and using mobile medical team personnel have been a great stimulation to the organization of such teams.

In 1942 General Olson, then a Colonel in the Army, went to Europe as Assistant Chief of Staff in the Eleventh Armored Division of General Patton's Third Army. He served in Europe until the end of the war.

Health Services, The Key to Civil Defense

I DEEM it a distinct honor and privilege to be guest editorialist for the *Wisconsin Medical Journal,* especially so because it gives me an opportunity to point with pride to the role that is being played by the medical profession in Wisconsin's civil defense.

I consider the medical phase to be one of the most important sections of our civil defense. And apparently Governor Kohler had the same thought in mind when he appointed Dr. Carl N. Neupert to serve as Co-Director for Health Services in our state civil defense organization. With Doctor Neupert at the helm, and with the cooperation and guidance of the State Medical Society and county medical groups, the medical phase of civil defense is in capable hands and is well along in its organization.

We in Wisconsin have attempted to build our civil defense on realistic and practical lines, utilizing, wherever possible, existing manpower, equipment, and supplies. I have had numerous conferences and private consultations with members and groups of the medical profession, and I am proud of their progress in building a solid organization. I have been especially impressed with their concept of the role of the medical profession in civil defense and with their understanding of how effectively they can serve their communities and the state.

We in the State Office of Civil Defense believe that the most effective civil defense will result from strong local programs designed to meet the specific needs of individual communities. The medical profession can and is playing a vital part in these local programs.

We recognize, however, that in the event of enemy attack no single community or group of communities will be able to meet the full impact of such a disaster. They will have to call on the rest of the state for help. To provide such help, the state civil defense mobile support program has been brought into being.

The 100 medical teams which are part of this support program are the key to saving lives. Their effectiveness will determine how many people will live and how many people will die.

It is then quite understandable that the teams should have the medicine, instruments, and other supplies they will need in order to care for the thousands of people who will need their specialized assistance. It is also obvious that these teams will need specialized training and practice so they can function as integrated units.

The State Office of Civil Defense has ordered medical supplies for these teams—medicine, bandages, litters, instruments, and radiologic monitoring instruments—at a cost exceeding $295,000. As soon as these supplies are received, they will be distributed to the teams or be stockpiled at easily accessible points. It is my hope that in the meantime all of the teams will complete their organization and undertake their special training, as well as conduct field tests to prove their proficiency.

The medical phase of civil defense, at the local level and at the state level, is moving forward. With the kind of assistance and cooperation that has already been demonstrated by the medical profession, Wisconsin will be prepared to care for its people if the enemy strikes.

Major General Ralph J. Olson

State Director of Civil Defense

. . . . THE PRESIDENT'S PAGE . . . .

Later Is Too Late

THIS, the June issue of the *Wisconsin Medical Journal,* is devoted to Civilian Defense. It is evidently high time that all of us begin to think seriously about this subject.

Our sense of responsibility has been dulled by the unpopularity of the Korean War, which many citizens think is a scare head designed to increase production for the support of our lagging economy. Our enthusiasm has been dampened by the monotonous repetition of arguments used to stimulate the purchase of bonds. Our apathy is based on the assumption that Russia is not ready to attack us. What may be a real danger leaves us unconcerned and unresponsive.

Our false sense of security, based on our location in the interior of the country, is unrealistic in this Air Age. Military authorities place Milwaukee in the upper fourteen most likely areas to be bombed. Some surveys place it near the top of the list because of its importance in the production of war materials.

Civic authorities and the schools have made considerable progress in organizing to meet their responsibilities. Medical preparation has lagged far behind, except in those large cities which consider themselves most vulnerable to attack, yet the vastness of the destruction produced by an atomic bomb would render those very cities helpless and make them dependent upon a large surrounding territory for medical, hospital and nursing care.

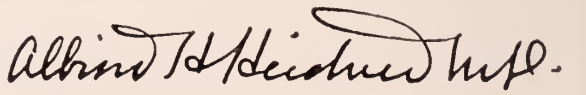
The authorities have, until recently, failed to provide sufficient funds for purchasing the materials necessary to properly train medical and auxiliary personnel. This difficulty is being overcome by one means or another until there is no longer any excuse to hold us back except the lethargy which affects all of us when a danger seems so remote.

Every one must realize that if we are attacked with either atomic bombs, gas, or biologic warfare, doctors must be prepared to meet situations which are unusual and with which they are unfamiliar. No previous education has fully trained them to meet such emergencies. Even if the first attack is in a distant part of the country, we will not have time to acquire the necessary knowledge or become familiar with the procedures and equipment which have been set up for our use unless every hospital, doctor, dentist, and nurse learns now what his particular job will be when needed.

The State has been divided into districts. The area Medical Directors have been chosen and have accepted their appointments. Many team captains are ready to go to work. It is now up to the rest of us to help and encourage them and to prepare ourselves for the work we will be called upon to do. If, as all of us hope, we are never attacked, our preparation will not be in vain. The trained workers, the equipment, and the speed with which a well organized medical team can be set at work may be of inestimable value should any type of major catastrophe occur.

One shudders to contemplate what might happen if a bomb did drop and we were not prepared. If everyone gets on the band wagon now and lends his enthusiastic aid to our leaders until the job is done, we will never have to regret our negligence. You will be told where you fit into the picture. When the call comes, please do your part.

We do not know that we will be attacked but we have no assurance that we will *not* be attacked. We had better be ready if and when the emergency arises.



535 North Dearborn Street, Chicago 10, Illinois

RICAN MEDICAL ASSOCIATION news notes JUNE, 1952

AMA news written especially for use in state medical journals

"Your Doctor" Movie to Be Distributed Nationwide

Of special interest to the medical profession is the short subject film—"Your Doctor"—now being released by RKO Pathe to theaters from coast to coast. This 17-minute film tells the story of the American Medical Association's contribution to modern medicine in the field of rural health and medical education. It will be available to all theaters through RKO Pathe distribution offices.

Tips for the Doctor's Secretary

Practical public relations techniques for dealing with the doctor's patients are included in two new illustrated booklets which the American Medical Association soon will make available to physicians. A 20-page pamphlet—designed as a brief guide for secretaries—will be sent to all AMA members. Especially valuable as a training guide for girls interested in becoming medical secretaries is the 60-page detailed manual which will be available July 1 to individual physicians through state medical society offices.

Industrial Health Platters Available July 15

A new series of electrical transcriptions on industrial health will be available from the AMA's Bureau of Health Education July 15 for use by local radio stations. The 13 programs in the series point up various phases of the industrial health field. Subjects include: eye problems in industry, the aging worker, the handicapped worker, women in industry, occupational disease control, alcoholism, psychological problems of the worker in relation to supervision, absenteeism control, off-the-job time, protective clothing and plant safety, family health, the white collar worker, and control of air and water pollution. Ben Park, noted radio and television announcer, narrates the series.

AMA Books Off the Press

The AMA's Council on Pharmacy and Chemistry announces that new editions of two of its major publications—"New and Nonofficial Remedies" and "Useful Drugs"—will be available this summer. The 1952 edition of "New and Nonofficial Remedies" retails for three dollars postpaid and "Useful Drugs" (15th edition) for $2.50 postpaid. Both may be secured through the publishers, J. B. Lippincott Co., Philadelphia, bookstores, or single copies through the AMA's Order Department.

New Medical Films

Several important medical and health films now are available to state and county medical societies through the AMA's Committee on Medical Motion Pictures. Films for the lay audience include "Be Your Age" (heart disease), "Breakdown" (mental health), "Man's Greatest Friend" (animal experimentation on rabies), and "The Nation's Mental Health." Suitable for professional meetings are "Functional Anatomy of the Hand," "The Quiet One" (psychiatry), "Sciatic Pain and the Intervertebral Disc," and "Shades of Gray" (psychiatry). These films are available on a service charge basis. An up-to-date and complete list of all films added to the library in the last few months can be obtained from the Committee.

Defense Department Asks for 450 Physicians in August Draft Call

Defense Department has called for drafting of 450 Priority I physicians in August; the Army would get 100 and the Air Force 350. As in the past, it is estimated that most of the doctors to be alerted for August will join the reserves in time to avoid induction through Selective Service. Health Resources Advisory (Rusk) Committee reports that for about a month now Army and Navy have been alerting some Priority II physicians that they are to be called, although none actually have gone on active duty. Committee estimates that by January 1, the pool of Priority I physicians will be about exhausted.

Facts about

Blue Shield of Wisconsin

an agency of the State Medical Society of Wisconsin

Prepared by the Commission on Prepaid Plans of the State Medical Society of Wisconsin,
E. M. Dessloch, Prairie du Chien, Chairman.

Surgical Coverage in New WPS Contract

What surgical services are provided?

The new Wisconsin Physicians Service contract offers benefits for surgical services for all participants. Surgical services are defined as "those operative procedures performed and recognized by doctors of medicine in the treatment of disease, conditions, and injuries." Usual pre- and postoperative care are included in this definition. Benefits for treatment of burns, fractures, and dislocations are provided.

Are there any limits on where surgery may be performed?

No. Benefits for surgery are payable whether the procedure is done in the hospital, physician's office, home, or elsewhere. There are no limitations of any kind requiring that service be rendered within a specified period of time after accidental injury.

What surgical services are not covered by the contract?

Benefits will not be provided for:

1. Operations performed primarily for cosmetic or beautifying purposes.
2. Injections of medications.
3. Any condition, disease, ailment, or injury covered by a Workmen's Compensation Act, or similar legislation, regardless of whether the participant elects to claim the benefits of such act or legislation.
4. Services furnished to a participant in any facility of, or otherwise provided by the United States Veterans Administration.
5. Services provided under the laws of the United States of America, or of any state or political subdivision thereof, where the participant or his property cannot be made liable for the cost thereof.
6. Any services other than those rendered by a licensed physician and surgeon.

Are surgical benefits affected by waiting periods?

Waiting periods may be waived. This is indicated on the face of the contract. If waiting periods are not waived, there is a nine months' waiting period with respect to benefits for services for any disease, condition, or ailment which existed on the effective date of the contract, the existence of which was known to the participant on such date.

In addition, the contract specifically provides that no benefits are payable for a period of nine months from the effective date of the contract for services rendered for benign tumors, varicose veins, hemorrhoids, cystocele or rectocele, prostatic conditions and tonsillectomies and adenoidectomies.

No waiting period applies to surgical care necessitated by an ectopic pregnancy.

What fees are paid for surgical procedures?

Fees are paid according to a fee schedule developed by a special fee committee representing general practice and the specialties, approved by the House of Delegates, and distributed to all physicians under the title "Schedule of Benefits for Prepaid Health Care Programs Approved by the State Medical Society of Wisconsin." If you have not received a copy, or if you have misplaced it, the State Medical Society office will be happy to send you a copy upon request.

Under the "old" Wisconsin Physicians Service contracts, some of which will be in effect until July 1, 1953, fees up to $150 for a single procedure are payable. Under the new "B" plan, now being sold, single procedures are payable up to $200. Under the new "A" plan, also being sold now, such procedures may be paid up to $300.

Formulas for specified multiple and multiple-stage procedures provide payments up to $500 and $700, depending on the procedures performed. These formulas are superseded by the printed Schedule of Benefits if an amount has been fixed for a multiple-stage procedure.

Reporting surgical procedures

Full and accurate information on the Physicians Service Report will speed payment of your claims.

Never hesitate to include more detailed reports of services rendered if it is felt that this information will be helpful in processing the claim. These may be submitted on separate sheets of paper attached to the Physicians Service Report, or the reverse side of the form may be used.

Clinical Results* with Banthine® Bromide

(Brand of Methantheline Bromide)

22 Published Reports Covering Treatment of 1443 Peptic Ulcer Patients with Banthine

Comprising the reports published in the literature to date which give specific facts and figures of the results of treatment

AUTHORS	No. of Patients	Chronic, Resistant to Other Therapy	TYPES OF ULCERS				RELIEF OF SYMPTOMS (Chiefly Pain)				Surgery or Compli-cations[1]	Side Effects Requiring Discontinuance of Drug[2]	EVIDENCE OF HEALING			
			Duodenal	Jejunal	Stomal	Gastric	Good	Fair	Poor	No Report			Complete	Moderate	None	No Report
Grimson, Lyons, Reeves	100	100	93	7			80	11	4		5		47		19	29
Friedman	15	15	14			1	5		4	6[3]			2			13
Bechgaard, Nielsen, Bang, Gruelund, Tobiassen	26	26	21			5	16	4	6				8	6	12	
McHardy, Browne, Edwards, Marek, Ward	162		162				136	12	11		3	1	14	9	7	129
Segal, Friedman, Watson	34	34	34[4]				14	13			7	2	5		8	14
Brown, Collins	117	99	117				97	7	8		5	8	55	9	8	40
Asher	77		65		7	5	52	9	16			16		9	21	47
Rodriguez de la Vega, Reyes Diaz	5	4	5				4		1					3	2	
Winkelstein	116	116	102	8		6	102		14				53		18	45
Hall, Hornisher, Weeks	18	18	18				11		1	6[5]			18			
Maier, Meili	38	38	24			14[6]	27	7	4[7]				10	2	5	21
Meyer, Jarman	25	18	25				21		4							25
Poth, Fromm	37	37	37				33	3	1				33	3	1	
Plummer, Burke, Williams	41	41	41				36		5				38		3	
McOonough, O'Neil	104	100	104				63	10	31			11	4		11	89
Broders	60	60	58		1	1	35	19	6				10	1	49[8]	
Legerton, Texter, Ruffin	11		11				11									11
Holoubek, Holoubek, Langlord	76	69	76				35	27	10		4	10	26		10	36
Ogborn	42		39	2		1	42[9]									42
Shaiken	48	48	48				33	10	3		2		33	10	3	
Johnston	145	145	145				143		2			2	143		2	
Rossett, Knox, Stephenson	146		141			5	146					4[10]	53			93
TOTALS	1443	968	1380	17	8	38	1142	132	131	12	26	54	552	52	179	634
PERCENTAGES		67.8	95.6	1.2	0.6	2.6	81.3	9.4	9.3			3.7	70.5	6.6	22.9	

1. Not included in tabulations.
2. Included in "Relief of Symptoms" as "Poor" and in "Evidence of Healing" as "None."
3. Four had no symptoms when Banthine therapy was begun.
4. Of which seven were penetrative lesions and five partially obstructive.
5. No symptoms were present in four.
6. Two with symptoms only; no demonstrable ulcer.
7. Three were psychopathic patients and one had a ventricular ulcer of the lesser curvature.
8. Roentgen findings after treatment period of two weeks, forty-seven had duodenal deformity.
9. All returned to work within a week
10. In these four, after relief of symptoms, Banthine was discontinued because of urinary retention.

During the past two years, more than 200 references to Banthine therapy in peptic ulcer and other parasympathotonic conditions have appeared in medical literature. Of these reports, 22 have presented specific facts and figures on the results of treatment in a total of 1,443 peptic ulcer patients, 67.8 per cent of whom were reported as chronic or resistant to other therapy. These results are tabulated above and show:

"Good" relief of symptoms was obtained in 81.3 per cent of the 1,405 patients on whom reports were available.

"Complete" evidence of healing was obtained in 70.5 per cent of the 883 patients on whom reports were available.

In all but 9.7 per cent, relief of pain was "good" or "fair." In all but 22.9 per cent, evidence of healing was "complete" or "moderate."

During treatment, 26 patients required surgery or developed complications other than ulcer which required discontinuance of the drug before results could be evaluated.

Of the remaining 1,417 patients, only 3.7 per cent experienced side effects sufficiently annoying to require discontinuance of the drug.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

*Volume containing complete references, with abstracts of 39 additional reports, will be furnished on request by

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COMMITTEE *Concentrates*

COUNCIL ON MEDICAL SERVICES

MAY 1

MDs Present: D. E. Dorchester, C. G. Reznichek, L. O. Simenstad, T. D. Elbe, R. L. MacCornack, and A. H. Heidner.

Reviewed status of medical-press conferences and recommended that a manual on "Handling Medical Publicity" be prepared for county secretaries and others concerned with press and radio contacts . . . Approved plan of preparing mats for newspapers, depicting such matters as the cost of a medical education, what an emergency is, and so forth, which could be inserted in local papers by county medical societies as an educational program. Approved proposed first-aid chart for distribution to 4–H Clubs and County Homemakers . . . Approved furnishing medical pamphlets to the Bureau of Information and Program Services of the U. of W. . . . Authorized the making of a survey to determine how emergency calls are being handled in the state, and preparing a report on the results.

COMMITTEE ON PUBLIC POLICY

MAY 3

MDs Present: J. M. Sullivan, S. E. Gavin, J. R. Schroder, M. G. Rice, R. S. Haukohl, J. S. Hirschboeck, and C. N. Neupert.

This being the first meeting of the Committee in preparation for the 1953 session of the legislature, the main portion of the meeting was directed to a proposed revision of Chapter 147 entitled "Treating The Sick." The specific recommendations of the Committee on Public Policy relative to proposed changes will be made in a separate report.

COMMITTEE ON COORDINATION OF MEDICAL SERVICES

MAY 4

MDs Present: S. B. Harper, S. E. Gavin, F. W. Kundert, W. H. Costello, T. W. Tormey, W. S. Middleton, H. M. Coon, and A. H. Heidner.

Purpose of meeting was to review admission records and policies of Wisconsin General Hospital. Review based on comparative figures for July–March 1951–52 and 1950–1951. Total patient days showed a decrease from 134,063 to 130,257, with latter figure for 1951–52 broken down as follows: state patient days, 80,035; special rate patient days, 21,377; private patient days, 28,845. Of the 9,323 admissions from July 1951–March 1952, 4,358 were state patients, 1,765 were special rate patients and 3,200 private patients . . . . Considerable discussion directed to special problems which arise when public or special rate patients treated at Wisconsin General Hospital have Blue Cross–Blue Shield coverage . . . Problem of special rate patients referred by welfare agencies also aired . . . Report made by Doctor Coon on Cerebral Palsy Center and other special projects, such as expanding the obstetric service, and doing additional work on problem children referred by the State Board of Health and the Department of Public Welfare . . . Report made that new space would accommodate about 215 more patients, increase net bed capacity by 150, and provide more facilities for teaching purposes.

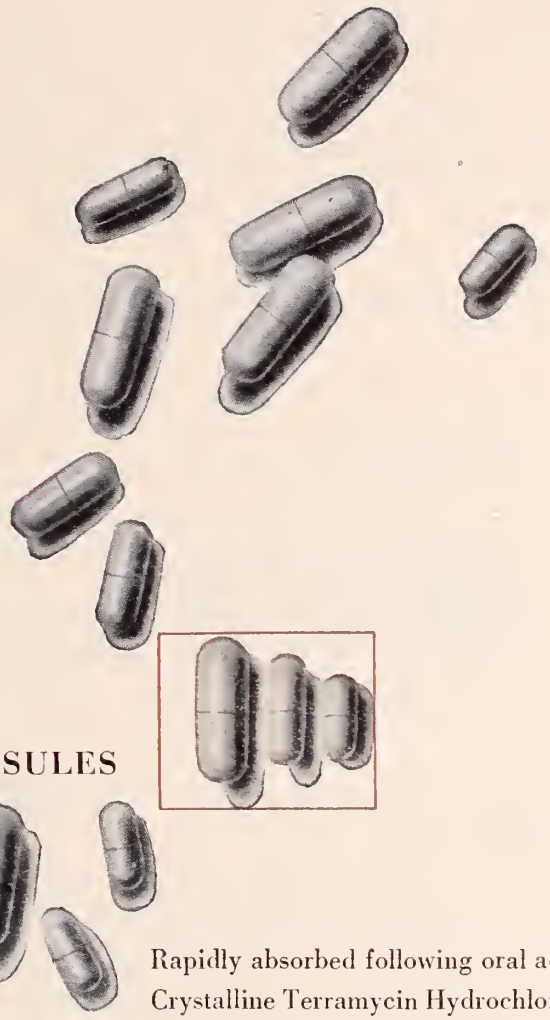
MENTAL HYGIENE, INSTITUTIONAL CARE AND STATE DEPTS.

MAY 4

MDs Present: A. M. Christofferson, W. J. Urben, E. D. Schwade, Mabel Masten, and L. A. Osborn.

Main purpose of meeting to review recommendations of special sub-committee appointed to study proposed changes in law relating to epilepsy and marriage. Report recommended elimination of portion of section 245.03 (1) of the 1951 Wisconsin Statutes which lumps the epileptic person with idiots, imbeciles, feeble-minded, and

Terramycin



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insane as those who are not permitted to marry. . . . Recommendations accepted and referred to Council (At May 18 meeting of Council favorable action taken, so that Committee on Public Policy was directed to prepare appropriate legislation and introduce it in the 1953 session.) . . . Committee asked to make special study of commitment laws, and to suggest changes which would eliminate the need to have a physician secure the action of law enforcement agencies to initiate commitment of patients for study and therapy. Special committee to be appointed. . . . Also, special sub-committee being appointed to study special problems of the psychotic child. . . . Doctor Osborn reported the necessity of providing better facilities for tuberculous patients in mental hospitals. Matter referred to Committee on T. B. and Chest Diseases.

MEDICAL ADVISORY COMMITTEE TO VETERANS MEDICAL SERVICE AGENCY

MAY 4

MDs Present: J. S. Supernaw, W. C. Finn, W. A. Fischer, J. L. Moffett, A. H. Heidner, H. M. Coon, S. E. Sebastian, and E. O. Ronneburger.

Discussion concerned itself primarily with the handling of psychiatric cases, with particular reference to admissions of such cases to Wisconsin General Hospital, and also the payment of transportation costs in cases where the patient elects to be examined and treated by a psychiatrist outside of his immediate area, and thus has to personally pay the difference in transportation cost. . . . Report made on meeting with VA officials in Washington, attended by Doctors Supernaw and Moffett and Mr. Doran, regarding the renewal of the contract and the establishment of agreement relating to administrative costs. Proposed contract as submitted by VA reviewed. . . . Approved resolutions of Arkansas and Tennessee Medical Associations regarding medical and hospital benefits for veterans with non-service connected disabilities and medical and hospital benefits for dependents of service personnel. Both resolutions protest use of facilities to the above categories. Resolutions to be acted upon by A.M.A. in June meeting.

MATERNAL AND CHILD WELFARE

MAY 10

MDs Present: L. M. Simonson, Amy Louise Hunter, Mildred Stone, Robert Purtell, A. H. Stahmer, Thomas Leonard, F. J. Hofmeister, Gordon Schulz, E. H. Pawsat, and Alice Watts.

Entire meeting directed to proposed study of maternal deaths, and perfection of form initially set up by sub-committee appointed to study the problem. . . . Tentative plan would call for contact with doctor following reported death, with effort made to secure information by mail. Then, follow-up by staff member of State Board of Health to secure further data for committee review. Agreed to have preliminary contact with every doctor and hospital before study launched to impress all with the purpose of the study as being purely educational and in no sense an investigation. . . . Matter referred to Council on May 18 and given "progress approval."

INTERIM COMMITTEE

MAY 16–17

MDs Present: A. H. Heidner, S. E. Gavin, J. C. Fox, J. M. Bell, R. G. Arveson, and R. E. Galasinski.

Preliminary meeting held on evening of May 16 with representatives of Wisconsin State Dental Society to discuss, informally, matters of mutual concern, such as hospital staff privileges, the incorporation of certain dental services in prepaid insurance plans, and problems of adequate representation of the various professions in the many health agencies of the state. . . . The following morning was devoted largely to a special conference with a citizens committee from River Falls, to discuss with them the special problems which have arisen in that community concerning use of the local hospital by an osteopathic physician. The Interim Committee also met with representatives of the Pierce–St. Croix County Medical Society to secure more information on the River Falls situation. . . . Approved suggestion that Committee on Public Policy meet with State Board of Medical Examiners in July to discuss problems of mutual concern. . . . Approved sending of letter to all members of SMS and members of the Wisconsin Pharmaceutical Association to clarify the regulations regarding the dispensing of dangerous drugs, as well as the recent communication which all druggists received from the secretary of the Wisconsin Pharmaceutical Association relative to this matter.

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COUNCIL

MAY 17–18

MDs Present: W. H. Costello, T. C. Hemmingsen, H. K. Tenney, H. E. Kasten, E. M. Dessloch, A. H. Heidner, A. J. McCarey, J. C. Fox, J. M. Bell, E. E. Kidder, R. G. Arveson, V. E. Ekblad, R. E. Galasinski, E. L. Bernhart, N. J. Wegmann, C. E. Zellmer, D. H. Witte, W. D. Stovall, R. E. Fitzgerald, F. L. Weston, S. E. Gavin, J. C. Griffith, Gunnar Gundersen, C. A. Olson, M. A. Cornwall, P. H. Gutzler, E. D. Schwade, and Mabel Masten.

Complete report of the Council meeting will be given in a subsequent issue of the Journal. These were the highlights: Approved request of Wisconsin Diabetes Association that it be recognized as a state-wide organization. . . . Approved appropriation of $250 to Woman's Auxiliary to assist the Department of Nursing Education in preparation and distribution of notebooks containing information on nursing courses; the notebooks to be sent to all high schools and colleges in Wisconsin. . . . Authorized president to submit nominees for State Department of Nurses study. . . . Approved recommendation of Veterans Medical Service Agency committee to oppose use of VA facilities for veterans with non-service connected disabilities. . . . Considered suggestion of certifying non-MD microbiologists. Vetoed suggestion that this be function of medical organizations. . . . Voted support of A.M.A. position in reference to Federal Department of Health. . . . Approved proposed letter to all members and pharmacists regarding interpretation of dispensing dispute. . . . Approved recommendation of Interim Committee that Committee on Public Policy meet with Board of Medical Examiners in July. . . . Approved Interim Committee recommendation that State Statutory Medical Grievance Committee be asked to act in case of physician who was issued license to practice in error. . . . Accepted quarterly report of Commission on Prepaid Plans showing growth of programs and financial support of Wisconsin Plan by affiliated companies. . . . Accepted recommendations of Committee on Mental Hygiene that legislation be introduced which will eliminate epileptic persons from wording of Section 245.03 (1) of 1951 Statutes. . . . Approved recommendations of Audit and Budget Committee that WPS schedules "A" and "B" be installed for SMS employees, with the "A" schedule subject to Wage Stabilization Board approval. . . . Approved printing and distribution of first-aid chart, as recommended by Council on Medical Service. . . . Approved renewal of contract with State Historical Society for continuation of historical research grant, not to exceed $2,500 for the next year only. . . . Heard reports from Messrs. John Tramberg and George Keith of the Department of Public Welfare concerning medical problems of special concern to that department. . . . Approved sending of letter to citizens committee of River Falls on the special problem brought before the Interim Committee the previous day.

RURAL HEALTH CONFERENCE COMMITTEE

MAY 26

MDs Present: R. L. MacCornack, M. W. Stuessy, W. D. Stovall, and A. A. Filek.

Purpose of the meeting was to prepare for the 1952 Wisconsin Rural Health Conference. Major problem is how to create a program that will stimulate local action in rural communities after the conference is held. Committee feels that regional conferences more effective than one state-wide meeting. Suggested topics for conferences: sanitation, school health, soil and nutrition, how to use existing health personnel and facilities, health insurance. Recommended preparation of tentative program for two conferences this fall—one in Madison, other in Wausau or Eau Claire—for presentation to meeting of 60 co-sponsors of the Rural Health conference. All plans subject to approval of Council of State Medical Society.

CLAIMS COMMITTEE

MAY 7
MAY 28

MDs Present: C. G. Reznichek, John Sprague, Nels Hill, and Robert Parkin.

Primary purpose of each meeting to settle claims and to develop a master fee schedule to be used in the office for the payment of unlisted claims. On May 28 the committee met with a committee of the Clinic Managers Association to review the new P.S.R. form.

From among all antibiotics, Orthopedic Surgeons often choose

New aureomycin minimal dosage for adults—four 250 mg. capsules daily, with milk.

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Hydrochloride Crystalline

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Aureomycin has been reported to be clinically effective against susceptible organisms in the following conditions frequently seen by the orthopedic surgeon:
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Throughout the world, as in the United States, aureomycin is recognized as a broad-spectrum antibiotic of established effectiveness.

Capsules: 50 mg.—Bottles of 25 and 100; 250 mg.—Bottles of 16 and 100. *Ophthalmic:* Vials of 25 mg. with dropper; solution prepared by adding 5 cc. of distilled water.

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SOCIETY PROCEEDINGS

Sixth District Medical Society

The Brown–Kewaunee–Door County Medical Society and its auxiliary were hosts to the Sixth District Medical Society when the District held its annual meeting at the Beaumont Hotel in Green Bay on May 8. *Dr. J. A. Killins,* Green Bay, presided as program chairman of the meeting which included a scientific session in the afternoon, followed by dinner, after dinner speakers, and a dance.

The speakers and their topics for the scientific session were as follows: *Robert M. Wylde, M. D.,* Madison, "Anesthesia in Smaller Communities;" *J. E. Gonce, M. D.,* professor of pediatrics at the University of Wisconsin, "Respiratory Obstruction in Infants;" Leo C. Massopust, director of the department of art and photography of Marquette University, "The Value of Infra-Red Phlebogram in the Diagnosis of Breast Complaints;" and L. Emmerson Ward, M. D., Rochester, Minn., "Current Treatment of Rheumatoid Arthritis and Allied Diseases."

While the doctors were attending the scientific session, their wives were entertained at a tea given by the Women's Auxiliary to the Brown–Kewaunee-Door Society. The Mmes. E. G. Nadeau and A. J. McCarey, chairmen, presided. Mrs. Oliver Hitch, social chairman of the auxiliary, and the Mmes. George Nadeau and R. J. Rose were in charge of arrangements for the dinner-dance which followed the afternoon functions.

The after dinner speakers included *Drs. A. J. McCarey,* Green Bay, councilor of the sixth district; *Dr. A. H. Heidner,* West Bend, president of the State Society; and Messrs. R. B. Murphy, legal counsel for the Society; and C. H. Crownhart, secretary of the Society.

Pictured above at the Sixth District Medical Society Meeting are (left to right) Mrs. O. M. Hitch, Auxiliary social chairman, Dr. J. A. Killin, general chairman of the meeting, Dr. and Mrs. A. H. Heidner, and Mrs. A. J. McCarey.

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*Gordon, Harry H.: Feeding of Premature Infants, American Journal of Diseases of Children 73:713 (June) 1947.

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Douglas

The scientific portion of the program of the Douglas County Medical Society featured two speakers from Superior. Meeting on May 7 at the Hotel Superior in Superior, the members of the Society heard addresses by *Drs. V. E. Ekblad* and *Milton Finn*. The topic chosen by the doctors was "Unusual Aspects of Railroad Surgery."

Green

Dr. D. D. Ruehlman was elected president of the Green County Medical Society at a meeting held on May 21 at the Monroe Country Club in Monroe. *Dr. J. A. Schindler* was elected vice president; and *Drs. L. G. Kindschi*, and *M. W. Stuessy*, Brodhead, were re-elected to the posts of secretary–treasurer and delegate respectively. Unless otherwise, stated, all of the officers are from Monroe.

Following dinner, the group heard a discussion of the new Blue Cross–Blue Shield insurance plans, which was presented by Byron C. Ostby, field secretary of the State Medical Society.

Jefferson

The April 17 meeting of the Jefferson County Medical Society was held at the Blackhawk Hotel in Fort Atkinson. *Dr. J. W. Brown*, professor of preventive medicine at the University of Wisconsin, was the guest speaker. His subject was "The Use of the Antibiotics in the Treatment of Infectious Diseases."

On the occasion of the May 15 meeting of the Society held at the Watertown Country Club, *Dr. E. J. Nordby*, Madison, addressed the group. "Common Foot Ailments" was the title of his paper.

Kenosha

"The Practical Approach to the Management of Infertility" was the subject of a paper by Dr. Armand J. Mauzey presented at the May 1 meeting of the Kenosha County Medical Society. Doctor Mauzey, who is an assistant professor of gynecology at the University of Illinois College of Medicine, discussed the causes of sterility and the various methods of treatment. He stated that there is an apparent increase in infertility and a growing difficulty in obtaining babies for adoption. In addition to his teaching duties, Doctor Mauzey conducts a clinic for infertility at the University of Illinois.

Richland

The Richland County Medical Society met on May 6 at *Dr. R. E. Housner's* cottage on the Wisconsin River. Following a roast turkey dinner, *Dr. E. T. Ackerman*, Muscoda, addressed the Society on "Mind and Magic." The second speaker was Mr. C. H. Crownhart, secretary of the State Society, who discussed "Medical Business and Ethics."

Sheboygan

The Sheboygan Clinic was host to the Sheboygan County Medical Society at its regular meeting which was held on the evening of May 15 at the Pine Hills Country Club. *Drs. A. R. Curreri* and *W. D. Stovall*, both of Madison, were the principal speakers. *Dr. A. H. Heidner* of West Bend, president of the State Medical Society, was present as a guest.

Trempealeau–Jackson–Buffalo

Members of the Trempealeau–Jackson–Buffalo County Medical Society met on March 20 at the Hotel Freeman in Black River Falls. On this occasion, *Dr. Robert Krohn* was in charge of the scientific program.

When the Society met at the Galesville Golf Club on May 15, the meeting included a dinner, a business session, and a round-table discussion on rural health and schedules A and B of the State Medical Society's prepaid health care programs.

Wisconsin Radiological Society

The third annual meeting of the Wisconsin Radiological Society was held at the Edgewater Hotel in Madison on May 16 and 17. On Friday evening there was a special meeting for the members of the Dane County Medical Society, the University of Wisconsin Medical School staff, and the staff of the Madison Veterans Hospital. The guest speaker was

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Dr. Harry M. Weber, chief of the section on diagnostic roentgenology at the Mayo Clinic, who presented a paper entitled "The Contribution of the X-Ray Examination to the Diagnosis of Early Cancer of the Alimentary Tract."

During the society's business session, officers were elected for the coming year as follows: *Drs. J. L. Armbruster*, Milwaukee, president; *R. L. Troup*, Green Bay, president-elect; *W. W. Moir*, Sheboygan, secretary-treasurer; *L. V. Littig*, Madison, *J. E. Habbe*, Milwaukee, and *E. A. Pohle*, Madison, board of censors; and *Carol Tomlinson*, Janesville, board of directors.

Wisconsin Surgical Society

Dr. J. W. Gale, Madison, was elected president of the Wisconsin Surgical Society at its meeting in Madison on April 26. Other officers who were elected are as follows: *Drs. Forester Raine*, Milwaukee, president-elect; *F. D. Weeks*, Ashland, secretary-treasurer; and *M. H. Steen*, Oshkosh, recorder.

Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology

A two-day program was attended by members of the Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology at Wisconsin Rapids, May 3 and 4.

The first afternoon's scientific program included movies on medical subjects, round-table discussions, and a paper on "Care of Trauma to the Nose" by Dr. Samuel Salinger of Chicago. Following dinner at the Hotel Mead, Dr. Walter Fink, Minneapolis, author of "Surgery of Oblique Ocular Muscles," spoke on "The Management of Vertical Muscle Defects."

The second day's program began with a continuation of Doctor Fink's talk, followed by a short business meeting and another paper by Doctor Salinger entitled "Correction of Septal and Nasal Deformities." The meeting was adjourned after a luncheon for members and their wives.

News Items and Personals

Pioneer Doctor Honored at Lone Rock Meeting

Dr. Bertha E. Reynolds of Avoca, formerly of Lone Rock, was the honored guest of the Lone Rock Lion's Club on April 24. The program was planned to commemorate her 50 years of service as a doctor in the Lone Rock area. A life member of the Iowa County Medical Society and the State Medical Society, Doctor Reynolds was presented with a certificate and pin signifying her membership in the Fifty Year Club of the Society.

The doctor graduated from the Woman's Medical College of Chicago in 1901 and then began her practice in Prairie du Chien. A short time later she moved to Lone Rock to practice.

Pictured above Dr. Bertha Reynolds is shown receiving her certificate of membership in the Fifty Year Club from Dr. E. M. Dessloch, Prairie du Chien. At the center is Dr. W. C. Edwards of Richland Center.

Wisconsin Heart Association Names Officers

Dr. L. R. Schweiger, assistant professor of medicine at Marquette University, was elected president of the Wisconsin Heart Association at its meeting in Madison on May 10. *Dr. H. H. Shapiro*, associate professor of medicine at the University of Wisconsin, was named president-elect; and Mr. Leon R. Wheeler, executive secretary of the Associated Hospitals Service, was elected secretary-treasurer.

Among the physicians named to the newly enlarged board of directors are *Drs. R. L. Rice* and *G. C. Owen* of Milwaukee; *P. D. Nelson, J. K. Curtis, R. N. Allin*, and *C. W. Crumpton* of Madison; *H. W. Harris*, La Crosse; and *R. C. Cantwell*, Shawano.

Physician Establishes Practice in Potosi

Dr. V. E. Spitznagle, who formerly worked with the Milwaukee City Health Department, has established his practice in Potosi. On the day of his arrival, the doctor was honored at a luncheon. Among those who attended were the committee members who had been active in obtaining a doctor for Potosi, the four doctors who had served the community temporarily, and the members of the county press. A graduate of the University of Maryland School of Medicine, Doctor Spitznagle had practiced in Baltimore for a number of years prior to moving to Wisconsin.

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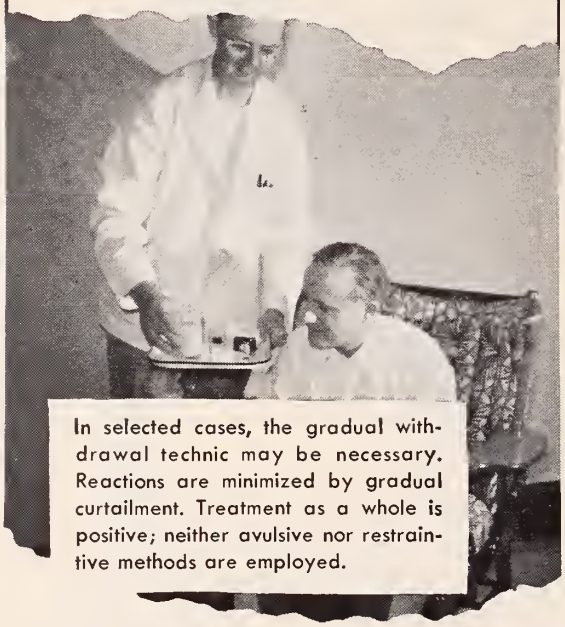

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Doctor Pfeifer Has New Associate

On April 9, *Dr. R. E. Bolinske* moved his office from Weyauwega to Clintonville where he will be associated with *Dr. R. H. Pfeifer.* Doctor Bolinske is a 1948 graduate of Marquette University School of Medicine and served his internship at Northwestern Hospital, Minneapolis. He also spent a year on the pediatric staff of the St. Louis University hospitals.

Wisconsin Association of Blood Banks Meets in Madison

On May 10, the Wisconsin Association of Blood Banks met in Madison at the Methodist Hospital. The meeting included a scientific program, business meeting and election of officers, and a banquet in the evening.

Dr. Myron Schuster, Racine, was elected president, and among the other officers chosen to serve with him were *Drs. J. B. Miale,* Marshfield, president-elect; and *O. R. Kelley,* Wausau, vice-president.

The speakers for the scientific program and their subjects were as follows: "Plans for Cooperation, Coordination, and Reciprocity Between Wisconsin Blood Banks, and the Role of the Wisconsin Association of Blood Banks in the Civil Defense Program," by Mr. R. F. Ambelang, business manager of the Junior League Blood Center of Milwaukee; "Organization of the Marathon County Blood Bank," by Doctor Kelley; "Our Experience with A and B Group Specific Substances in Modifying Group O Blood," by Doctor Miale; "Rh Technics and Their Adaptation," by Miss Ruby Bere, Wisconsin State Laboratory of Hygiene, Madison; "Use and Abuse of Blood," by Dr. S. O. Levinson, executive director of the Michael Reese Research Foundation of Chicago; and "Should Other Solutions Be Used With Blood?", by *Dr. L. J. Kreissl,* Milwaukee.

Doctor Jaffe Opens Office in Nekoosa

Dr. Marvin Jaffe, former Chicago physician, recently opened an office in Nekoosa. The doctor graduated from Northwestern University and received his medical degree from the University of Chicago School of Medicine. He served his internship at Cook County Hospital, Chicago, and had been in private practice for a year before moving to Nekoosa.

Doctor Brook Begins Practice in Marshfield

A new member on the staffs of the Marshfield Clinic and St. Joseph's Hospital, Marshfield, is Dr. J. J. Brook, who assumed his new duties on April 1. Doctor Brook, a native of Wauwatosa, received his medical training at Northwestern University Medical School and served his internship at Milwaukee County Hospital. Prior to moving to Marshfield, he was a resident on the staff of the Luther Hospital in Eau Claire.

THIRD AND TWELFTH DISTRICT NEWS

Doctor Reese to Serve in New Posts

Dr. Hans H. Reese, professor of neuropsychiatry at the University of Wisconsin, was elected seventy-seventh president of the American Neurologic Association at its meeting in Atlantic City on May 9. He has also been appointed chairman of the medical advisory board of the National Society for Multiple Sclerosis and Research, in addition to his position as medical director of the National Association of Muscular Distrophy and Atrophy Research of New York City.

Doctor Jackson Receives Medal of Honor

Dr. Arnold S. Jackson, Madison, sailed on May 6 on the Queen Elizabeth to attend medical meetings in Bordeaux France; Barcelona and Madrid, Spain; Vienna, Austria; and Amsterdam, Holland. At the meeting of the French Chapter of the International College of Surgeons, held in Bordeaux, Doctor Jackson and four other United States surgeons received medals of honor from the faculty of medicine of the University of Bordeaux. Doctor Jackson will attend the chapter meetings in Barcelona, Amsterdam and Vienna, before attending the biennial international meeting of the College in Madrid.

Doctor Mac Kay Resigns U. W. Post

Dr. A. M. Mac Kay, chief of the anesthesia division of the department of surgery of the University of Wisconsin Medical School, has resigned from this post effective as of May 31. Doctor Mac Kay is planning to enter private practice on the West Coast.

Doctor Boner Attends Postgraduate Courses

Dr. Albert J. Boner, Madison, is attending postgraduate courses at the Cook County Graduate School of Medicine. Doctor Boner, who established his practice in Madison in 1928, is an associate in clinical medicine at the University of Wisconsin.

Papers Presented by Two U. W. Professors

Two University of Wisconsin faculty members, *Dr. J. W. Gale*, professor of surgery, and *Dr. C. M. Kurtz*, associate professor of medicine, addressed the meeting of the Indiana Academy of General Practice which was held in Elkhart, Indiana on April 3. Doctor Gale's subjects were "Carcinoma of the Lung" and "Problems in Thoracic Surgery;" and Doctor Kurtz discussed "The Present Status of the Medical and Surgical Treatment of Hypertension" and "Newer Concepts of Atherosclerosis."

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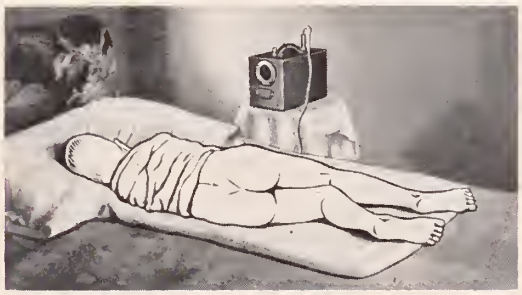

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Dane

Commander John Seal, who is in charge of the Great Lakes, Illinois, Naval Medical Research Unit, was the guest speaker at the May 13 meeting of the Dane County Medical Society which was held at the Veterans Administration Hospital in Madison. Commander Seal chose "Treatment and Control of Infectious Diseases" as the subject of his talk.

Sauk

The members of the Sauk County Medical Society met on May 13 at the Warren Hotel in Baraboo. The first guest speaker was *Dr. Sture A. M. Johnson*, professor of dermatology at the University of Wisconsin, who spoke on "Diagnosis and Treatment of the Common Dermatoses." This talk was followed by a discussion on medical problems which was delivered by *Dr. H. E. Kasten* of Beloit, one of the councilors of the third district. During the business meeting, the members approved holding a picnic the first week in June, as well as passing the motion that health examinations for the seniors of the Normal School be done free of charge.

Promotions at Marquette Announced

Dr. A. B. Schwartz, associate clinical professor of pediatrics, has been named acting director of the pediatrics department at Marquette University. He replaces the late Dr. Francis R. Janney. Also promoted were *Dr. E. A. Bachhuber*, former associate in surgery, and K. D. Brown, Ph. D., former instructor in biochemistry, both of whom received assistant professorships.

Physicians Named to Board of Directors

Among the physicians elected to the board of directors of the Multiple Sclerosis Society of Milwaukee were *Drs. A. J. Baumann, F. P. Falsetti, H. R. Weil,* and *J. R. Hurley*. The society was organized recently to aid the estimated 1,000 cases of multiple sclerosis in the Milwaukee area.

Milwaukee Pediatrician Addresses Medical Groups

Dr. M. G. Peterman, a Milwaukee pediatrician, addressed the New Mexico State Pediatric Society in Albuquerque, N. M., on May 7, as well as addressing the seventieth annual session of the New Mexico Medical Society in Carlsbad on May 8 and 9. Doctor Peterman also presented a paper at the May 13 joint meeting of the San Diego County Medical Society and the San Diego Academy of Medicine.

Milwaukee

Four advertising and public relations men discussed medical public relations at the May 1 meeting of the Medical Society of Milwaukee County. The speakers were Ben Barkin, president of Ben

Barkin and Associates; Frank V. Birch, president of Klau–Van Pietersom–Dunlap Associates; John H. Paige, vice-president in charge of public relations of the Wisconsin Telephone Company; and Leo Brown, director of public relations of the American Medical Association.

Milwaukee Academy of Medicine

Dr. John P. Peters, professor of medicine at Yale University School of Medicine, was the guest speaker at the May 20 meeting of the Milwaukee Academy of Medicine. The subject chosen by Doctor Peters was "Application of Modern Chemistry to Medicine." As usual, a social hour and dinner preceded the scientific program.

Milwaukee Neuro-Psychiatric Society

A panel discussion on "Benefits for Neuropsychiatric Patients Under Blue Cross" was held at the May 21 meeting of the Milwaukee Neuro-Psychiatric Society. The speakers panel included *Dr. R. A. Jefferson,* "The Practitioner's Viewpoint;" *Dr. W. H. Studley,* "From the Standpoint of the Sanitarium;" Mr. L. R. Wheeler, executive secretary of Associated Hospital Services, "From the Insurance Viewpoint;" and Mr. James O. Kelley, executive secretary of the Medical Society of Milwaukee County, "From the County Medical Society's Position."

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DEATHS

HARRY PERRIN

Several years ago on a colorful October afternoon six doctors, accurately fitted in a Ford touring car, were on their way to a county medical meeting at River Falls.

As the car descended a hill into the beautiful Kinnickinnic valley, **Dr. Harry Perrin** called from the rear seat, "Doctor, will you kindly stop at the next crossroad, there is something you all should see." The car stopped. All got out, and Harry solemnly removed his hat, saying "Gentlemen, please." Then pointing at a farm house he hoarsely whispered, "I was born right there." How we loved that man.

Until the winter of 1951 Harry had warmed the hearts of thousands with his subtle, kindly wit and charm and his ministrations. He had practiced in Star Prairie for over 58 years and was a life member of the Pierce–St. Croix County Medical Society, the State Medical Society, and American Medical Association.

Today we again remove our hats. This time with different emotions, in memory of Dr. H. E. Perrin, for on March 18, 1952 he died at Lakeview Memorial Hospital in Stillwater, Minnesota.

He was born in Kinnickinnic May 30, 1869, son of William Louis and Frances Perrin. He was graduated from Northwestern University in 1894, and two years later married Mary Stuart Hallett. Surviving are one son, Stuart, also a physician and now practicing in Superior; and two daughters, Mrs. Joye L. Johnson, New Richmond, and Mrs. Robert Hendry, Aurora, Ill.—*Prepared for the Journal by Dr. O. H. Epley, New Richmond.*

Dr. Herbert T. Barnes, 76, Delafield physician, died on May 15 in a local hospital. He was born in Elkhorn on April 23, 1876.

After graduating from Rush Medical College, he interned at St. Francis Hospital, Colorado Springs, Colorado. He served in the first World War and for a short time made his home in Pewaukee.

Long active in Delafield community affairs, Doctor Barnes served as health officer of the town for 29 years and was medical officer at St. John's Military Academy for 32 years. As a token of their appreciation the local chamber of commerce recently presented him with a watch and the residents of Delafield presented a television set.

A former president of the Waukesha County Medical Society, the doctor was also a member of the State Medical Society, and the American Medical Association.

Survivors include his wife, one son, and two daughters.

A practicing physician in Milwaukee for 45 years, **Dr. Bernard H. Oberembt**, 75, died on April 24 at a hospital in Wood following a six months illness.

Born in Springfield, Wisconsin on May 19, 1876, the doctor graduated from Rush Medical College in 1903 and did postgraduate work in Vienna, Austria. He established his practice in Milwaukee in 1907. Before the United States entered World War I, he served with eight other Milwaukee physicians in a hospital unit in Vienna, sponsored by Milwaukeeans. Returning to the United States, he served in the naval reserves in 1917 and 1918.

Doctor Oberembt was a member of the Medical Society of Milwaukee County, the State Medical Society, and the American Medical Association.

Survivors include his wife, two sons, and a daughter.

Dr. William J. Murawsky, 48, Burlington physician, died suddenly on April 23. He was born in Milwaukee on May 16, 1904.

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He was a graduate of Marquette University School of Medicine and served his internship at Providence Hospital in Detroit, Michigan. Establishing his first practice in Lyons in 1930, the doctor moved his office to Burlington in 1943.

At the time of his death Doctor Murawsky was health officer for the village of Lyons and had formerly served as chief of staff at the Burlington Hospital. A charter member of the Wisconsin Chapter of the American Academy of General Practice, he was a member of the board of directors of the Academy as well as a member of the Walworth County Medical Society, the State Medical Society, and the American Medical Association.

He is survived by his wife and two sons.

Dr. Walter E. Mueller of Green Bay died on April 23 in a local hospital following a long illness. He was 61 years old.

Born in Green Bay on August 14, 1890, the doctor received his medical education at the University of Illinois College of Medicine, graduating in 1914. He interned at the West Side Hospital in Chicago and then established his practice in Shawano. He served in the medical corps during World War I, and in 1920 moved his office to Green Bay.

For many years he was chief of staff of Bellin Memorial Hospital and he was recently reelected surgeon of the local VFW post. In 1947 he was appointed chief medical officer for the Green Bay sub-regional office of the Veterans Administration.

A past president of the Brown–Kewaunee–Door County Medical Society, Doctor Mueller was a member of the American Medical Association.

Survivors include his wife, a son, and two daughters.

Dr. Harry E. Gillette, 74, retired Pardeeville physician, died suddenly in Madison on April 22. He was born in Canton, Illinois on June 25, 1878.

A 1908 graduate of the Milwaukee Medical College, now Marquette University School of Medicine, the doctor established his first practice in Berlin and also practiced in Packwaukee and Amherst Junction prior to serving in the medical corps during World War I. Upon his discharge, he established his practice in Pardeeville where he was active until his retirement in 1947.

Doctor Gillette was a past president of the Child Advisory Board of Columbia County and a member of the County Health Committee, as well as having served two terms on the school board. A past president and also past secretary of the Columbia–Marquette–Adams County Medical Society, the doctor was also a member of the State Medical Society and the American Medical Association.

He is survived by his wife.

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Address as follows: Medical Library Service, Service Memorial Institute Building, North Charter Street, Madison, Wisconsin.

Low-Sodium Diet—A Manual for the Patient. By Thurman B. Rice, A.M., M.D., professor of public health, Indiana University School of Medicine, Indianapolis, Indiana. Philadelphia, Lea & Febiger, 1951. Price $2.75.

This guide is written in non-technical language for laymen requiring a low sodium diet and for those who must prepare foods with a minimum of sodium content. It is intended to supplement the guidance and treatment by the physician, not to replace it. Salt content of foods is given as well as how to prepare them, and what to do when eating out. Symptoms of hyponatremia are listed. It is a useful book for instruction of the patient.—E.C.A.

The Public Health Nurse and Her Patient. By Ruth Gilbert, R.N., coordinator, course for mental hygiene consultants, and assistant professor of nursing education, Teachers College, Columbia University. Cambridge, Mass., Harvard University Press, 1951. Price $3.75.

This revised edition of a book which has been found valuable as a text for students and as a reference for the practicing nurse differs from the original more in point of emphasis than in subject matter. The entire theme which has to do with the nurse's relationship to her patient is treated entirely within the framework of present concepts of the dynamics of human behavior. Through the use of a wide variety of pertinent and practical illustrations the author shows how a better knowledge of human behavior fortifies the nurse and how the nurse, in turn, can fit in with the current mental hygiene movement.

In the chapters relating to the teaching of health, recognition is given to the difficulties encountered by the nurse who, charged with a sense of responsibility for teaching, finds that her aims are often incompatible with those of the patient. Throughout the author's treatment of this subject she stresses the point that while information about health and illness are part of the nurse's essential equipment that a non-judgmental, non-authoritative attitude that leads to a useful relationship with patients is basic in her work with all ages and in all situations. She shows again and again how the nurse can respond to the feelings and the fears which lie behind what the patient says or behind his resistance to a course of action.

The chapters dealing with the maternity patient and the child in its family stress the importance of these periods for development of resources within the individual and shows how the nurse has a "natural" preventive function in the fostering of healthy growth. Many problems relating to familiar training situations are treated with penetration and in recognition of present knowledge of child growth.

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The title of the book would suggest that the material is directed largely to the nurse in public health. It seems, however, that the wide range of situations which are presented have validity and pertinence to all types of nursing. This is particularly true of the chapters on Nursing the Sick Patient which deal with attitudes toward illness and disability, as well as the nurse's attitude toward giving bedside care.

While the chapter on Relationships With Co-workers is focused on community situations, it would seem that its implications are equally significant for the hospital nurse whose thinking is being increasingly geared toward the "team approach" in the care of the patient.

Probably the greatest value of this book is that it brings into a form that is useable for nurses many of the concepts and approaches which have hitherto been applied mainly in the fields of psychiatry and social work.—M.R.J.

Multiple Sclerosis; Application of Rehabilitation Techniques. By Edward E. Gordon, M.D., department of physical medicine and rehabilitation at New York University–Bellevue Medical Center, New York City. New York, National Multiple Sclerosis Society, 1951.

This is an excellent monograph on rehabilitation techniques, specifically in multiple sclerosis, but the methods are equally applicable to many other neurologic conditions.

Sections 1 and 2 constitute an excellent presentation of the aims and philosophy behind the present day treatment of neurologic conditions. It ably dispels the defeatist attitude shared by students and physicians. It should be a required reading assignment.

The remainder of the book describing methods of examination, therapy, evaluation, and grading of the patient's progress is more difficult to appraise. Again the presentation is excellent, but necessarily too superficial for the specialist in neurology or physical medicine. Therefore, its greatest use would be to give hope and outline a plan of treatment for the patient and general practitioner. I am not sure that the writer had a definite reader in mind, perhaps in future editions one could be written for the patient.—E.P.R.

A Textbook of Clinical Neurology. By J. M. Nielsen, B.S., M.D., F.A.C.P., clinical professor of neurology and psychiatry, University of Southern California; senior attending physician (neurology) Los Angeles General Hospital; attending neurologist, Hospital of the Good Samaritan and Methodist Hospital, Los Angeles, California. Third edition. New York, Paul B. Hoeber, Inc., 1951. Price $10.00.

In 1941 a new textbook on clinical neurology made its bow. Although certain shortcomings were noted at that time, this text was foredestined to make an enviable place for itself. This was assured by the

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nature of its author. A forthright person, careful, thoughtful student and observer, prodigious worker, with a love for neural anatomy and neuropathology —these qualifications are a guarantee of sound practical neurologic teaching. One sees and feels these qualities in his text.

The author's style is simple, unadorned and informal as if he were talking to his students. He is most at home in the chapters dealing with cerebral localization, brain and spinal tumors, vascular disease, and syndromes referred to the several parts of the nervous system, for in these areas his complete familiarity with anatomic structure and his studious application of careful clinical observation in terms of structural change make these chapters of decided teaching value. The chapter on cerebral localization deserves especial commendation. It is richly illustrated with the very finest of photographic reproductions of the author's wealth of pathologic material. Throughout the book, illustrations are of high order.

This third edition which has been completely worked over, shows improvement in certain areas somewhat neglected in the earlier editions, new material has been added (angiography) and some topics have been rewritten to bring them up to date with current knowledge.

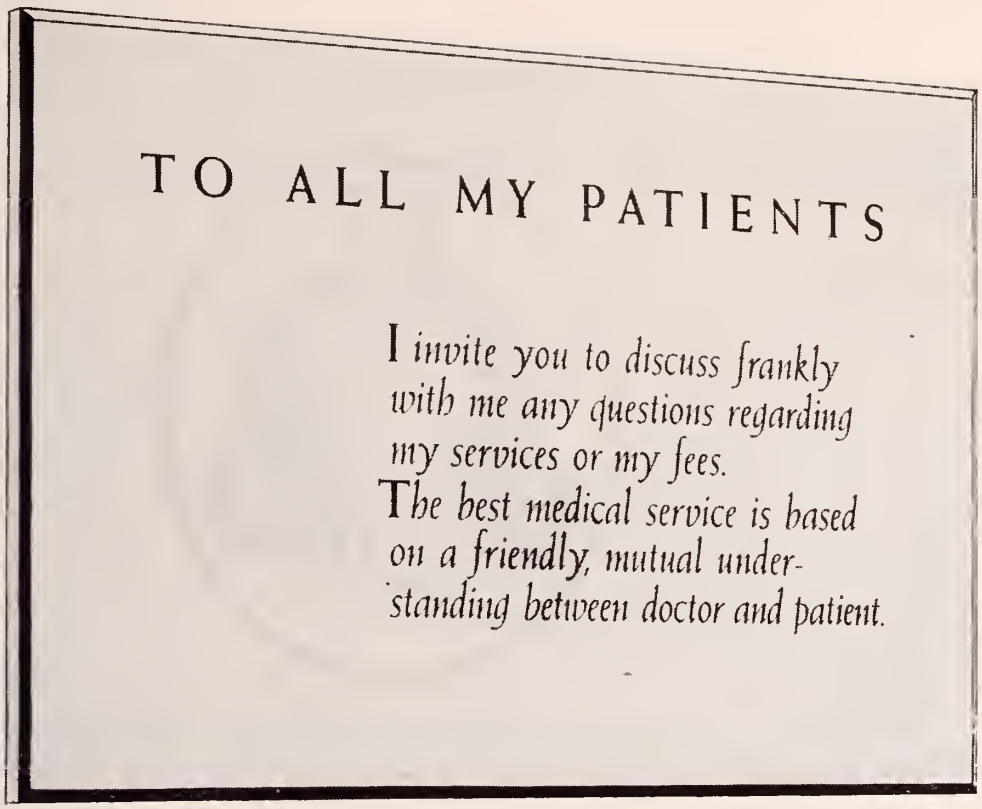
A reviewer is considered uncritical if he fails to frown on some part of the production or to record errors. By this time the author's friends have advised him of the latter (there are a few in this volume); with regard to weak or thin spots, it is well to point out that reviewers have biases in the same proportion as authors have strong and weak areas in their books. Authors must depend on the work of others to supplement their own knowledge gained by personal experience. Those subjects with which they have had richest experience always highlight the text just as it surely does in this case. This is an excellent text for students of neurology and is deserving of the position it now occupies in the field of medical text books.

A comment directed to the publisher seems in order. The paper is thick, adding unnecessary weight to a book of 700 pages, and the glossy surface acts as a reflecting medium causing annoyance when reading by artificial light.—M.G.M.

Review of Physiological Chemistry. By Harold A. Harper, Ph.D., professor of biology (biochemistry), University of San Francisco; lecturer in surgery, University of California School of Medicine, San Francisco; biochemist consultant to Metabolic Research Facility, U. S. Naval Hospital, Oakland; Director, Biochemistry Laboratory, St. Mary's Hospital, San Francisco. Third edition. Palo Alto, California, University Medical Publishers, 1951. Price $3.50.

"This review is intended as a supplement to the standard texts . . ., as a companion volume to the student . . . and as a review for the physician preparing for state and specialty boards." These are the purposes of the book as announced by the author. Considered solely as a biochemical reference work, such a volume is not expected to be adequate, and it is hard to believe that it would actually be of value in a standard medical school course except as a crutch for the weaker students. However, within the framework of a review for the busy physician with his classroom days behind him, the author has performed skillfully.

The short chapter on liver function tests, perhaps the best summary in print, would alone justify the modest price, and the section on the kidney is almost as good. As might be expected, the compression of the vast amount of data on metabolism into a short space is less successful. Particularly in the discussion of amino acid metabolism, the picture of the principal pathways is not clear, and the reader would get a false impression of the significance of the more bizarre compounds. For some reason, these seem to fascinate textbook writers in general. To be fair, it must be emphasized that even in these sections, the author has striven to present the latest established concepts, and the instances in which he is out of date are rare. Those desiring more information are given an excellent general reference list at the close of the volume.—R.W.M.



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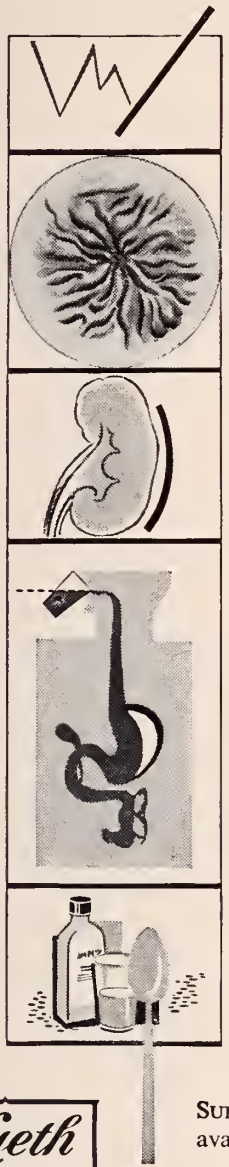

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Stephen E. Gavin, Fond du Lac, 1952 D. H. Witte, Milwaukee, 1952 William D. Stovall, Madison, 1953

Alternates

L. O. Simenstad, Osceola, 1952 Joseph C. Griffith, Milwaukee, 1952 D. J. Twohig, Fond du Lac, 1953

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List of Officers and Scheduled Meetings of County Medical Societies

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Ashland-Bayfield-Iron	C. A. Grand 522 W. 2nd Ashland	J. E. Kreher 522 W. 2nd St. Ashland	
Barron-Washburn-Sawyer-Burnett	R. E. Lund Cumberland	Clive J. Strang Barron	Second Tuesday 7:30 p.m.
Brown-Kewaunee-Door	J. L. Ford 3030 S. Webster Green Bay	G. M. Shinners 409 E. Walnut Green Bay	Second Thursday*
Calumet	E. P. Larme New Holstein	L. W. Keller Brillion	
Chippewa	T. D. Foster Cornell	B. F. Rahn Cadott	Second Tuesday
Clark	K. F. Manz Neillsville	G. G. Shields Abbotsford	
Columbia-Marquette-Adams	R. F. Inman Montello	E. G. Nafziger Oxford	Second Tuesday 7:00 p.m.
Crawford	O. E. Satter Prairie du Chien	H. L. Shapiro Prairie du Chien	
Dane	G. H. Ewell Jackson Clinic Madison	G. C. Hank 110 E. Main Madison	Second Tuesday
Dodge	C. L. Qualls Beaver Dam	R. E. Urbanek Beaver Dam	Last Thursday
Douglas	C. T. Droege 1507 Tower Superior	R. T. Anderson 1507 Tower Superior	First Wednesday** Badger Room of the Hotel Superior
Eau Claire-Dunn-Pepin	W. G. Cameron 131 S. Barstow Eau Claire	H. E. Sorensen 314 E. Grand Eau Claire	Last Monday
Fond du Lac	R. W. Steube St. Agnes Hospital Fond du Lac	H. R. Sharpe 92 E. Division Fond du Lac	Fourth Thursday*
Forest	O. S. Tenley Wabeno	B. S. Rathert Crandon	
Grant	N. G. Rasmussen Montfort	H. W. Carey Lancaster	Last Thursday, March, June, Sept. and Nov.
Green	D. D. Ruehlman Monroe	L. G. Kindschi Monroe Clinic Monroe	
Green Lake-Waushara	Roy Hong Wild Rose	R. S. Pelton Markesan	Last Thursday, every other month starting in Jan.

List of Officers and Scheduled Meetings of County Medical Societies—Continued

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Iowa	C. L. White Mineral Point	H. M. Walker Dodgeville	First Thursday following first Monday
Jefferson	E. A. Miller 133 Riverlawn Watertown	E. J. Netzow Lake Mills	Third Thursday*
Juneau	J. S. Hess Mauston	M. S. Tverberg Mauston	Second Tuesday Hess Clinic in Mauston
Kenosha	H. L. Schwartz 625 57th Kenosha	Helen A. Binnie 7609 25th Kenosha	First Thursday* Elks Club Kenosha
La Crosse	J. J. Satory 1707 Main La Crosse	D. M. Buchman 308 Newburg Bldg. La Crosse	Third Monday
Lafayette	D. J. Garland Shullsburg	N. A. McGreane Darlington	First Tuesday
Langlade	D. W. Dailey Elcho	F. H. Garbisch Antigo	Second Wednesday
Lincoln	L. J. Bayer Merrill	J. D. Millenbah Merrill	
Manitowoc	C. J. Radl Wood Block Manitowoc	W. C. Randolph 819 Hancock Manitowoc	Last Thursday
Marathon	D. M. Green Trust Bldg. Wausau	G. R. Hammes 529½ 3rd Wausau	
Marinette–Florence	J. M. Bell 1723½ Main Marinette	R. J. Rogers Oconto	Third Wednesday St. Joseph's Hospital
Milwaukee	N. J. Wegmann 2510 W. Capitol Milwaukee	W. T. Casper 2218 N. 3rd Mr. J. O. Kelley, Ex. Sec. 208 E. Wisconsin	Second Thursday
Monroe	C. E. Kozarek Tomah	J. S. Mubarak Tomah	Third Monday
Oconto	H. A. Aageson 1113 Main Oconto	G. R. Sandgren Suring	
Oneida–Vilas	G. R. Thuerer 1020 Kabel Rhinelander	Marvin Wright 1020 Kabel Rhinelander	Monthly
Outagamie	L. B. McBain 128 N. Durkee Appleton	W. A. Adrians 118 W. College Appleton	Third Thursday* Elks Club 6:30 p.m.
Pierce–St. Croix	E. F. Hill Spring Valley	P. H. Gutzler River Falls	Third Tuesday
Polk	W. A. Fischer Frederic	G. B. Noyes Centuria	
Portage	M. G. Rice Stevens Point	H. A. Anderson Stevens Point	
Price–Taylor	J. L. Murphy Park Falls	J. J. Leahy Park Falls	Last Saturday, Feb., May, Aug., and Nov.
Racine	J. M. Albino 710 Main Racine	J. G. Jamieson 812 Main Racine	Third Thursday
Richland	J. I. Spear Richland Center	L. M. Pippin Richland Center	First Tuesday Richland Hospital
Rock	M. M. Baumgartner 508 W. Milwaukee Janesville	J. F. Pember 508 W. Milwaukee Janesville	Fourth Tuesday
Rusk	L. M. Lundmark Ladysmith	M. L. Whalen Bruce	First Tuesday
Sauk	E. V. Stadel Reedsburg	J. J. Rouse Reedsburg	Second Tuesday*
Shawano	J. H. Terlinden Bonduel	R. C. Cantwell Shawano	Third Tuesday
Sheboygan	J. E. Martineau Elkhart Lake	J. F. Hildebrand 1011 N. 8th Sheboygan	First Thursday
Trempealeau–Jackson–Buffalo	F. T. Weber Arcadia	E. P. Rohde Galesville	Third Thursday
Vernon	L. F. Gulbrandsen Viroqua	C. A. Ender Viroqua	Last Wednesday
Walworth	R. S. Galgano Delavan	K. C. Bill Elkhorn	Second Thursday*
Washington–Ozaukee	P. B. Blanchard Cedarburg	K. F. Pelant Grafton	Fourth Thursday
Waukesha	J. C. Frick 262 W. Broadway Waukesha	J. A. Bartos 707 Oakland Waukesha	
Waupaca	L. G. Peterson 122 S. Main Waupaca	R. E. Bolinske Clintonville	
Winnebago	W. E. Clark 19 Jefferson Oshkosh	B. S. Greenwood 19 Jefferson Oshkosh	First Thursday
Wood	E. E. Debus Wisconsin Rapids	R. W. Mason Marshfield	Four times a year

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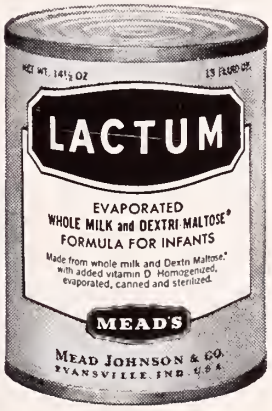

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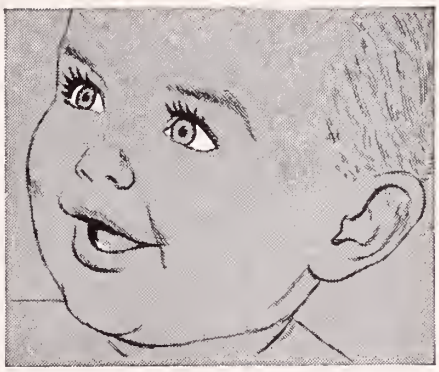
*Frost, L. H., and Jackson, R. L.: Growth and Development of Infants Receiving a Proprietary Preparation of Evaporated Milk with Dextri-Maltose and Vitamin D, J. Pediat. 39:585-592 (Nov.) 1951.



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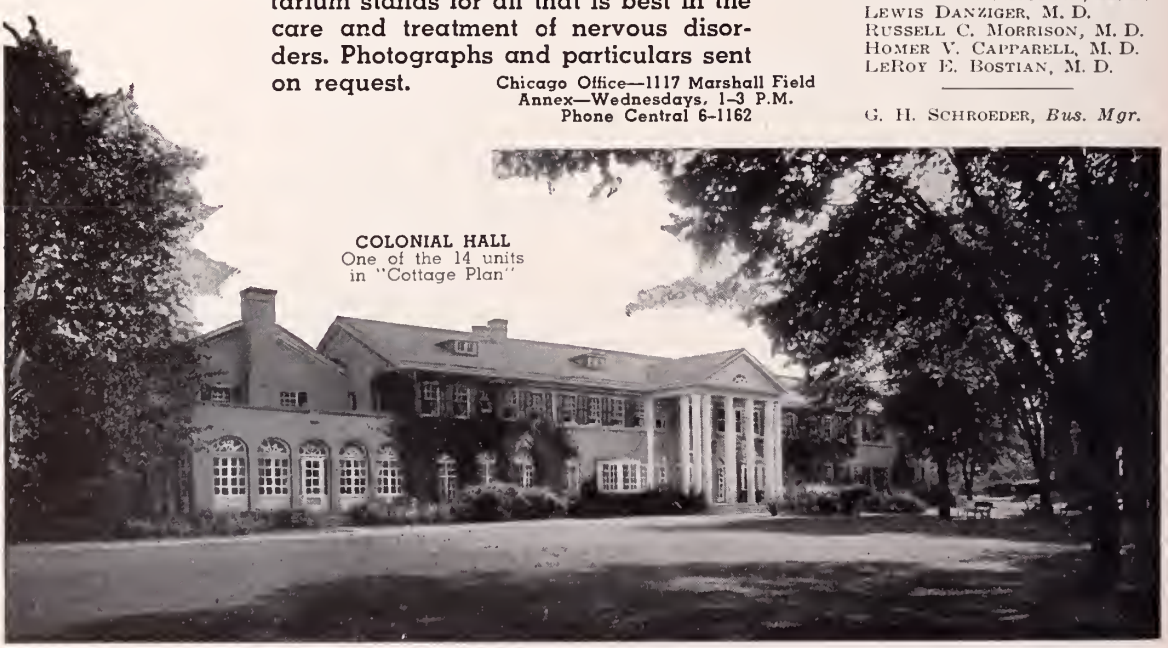

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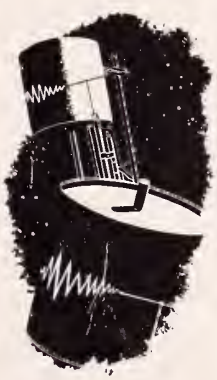

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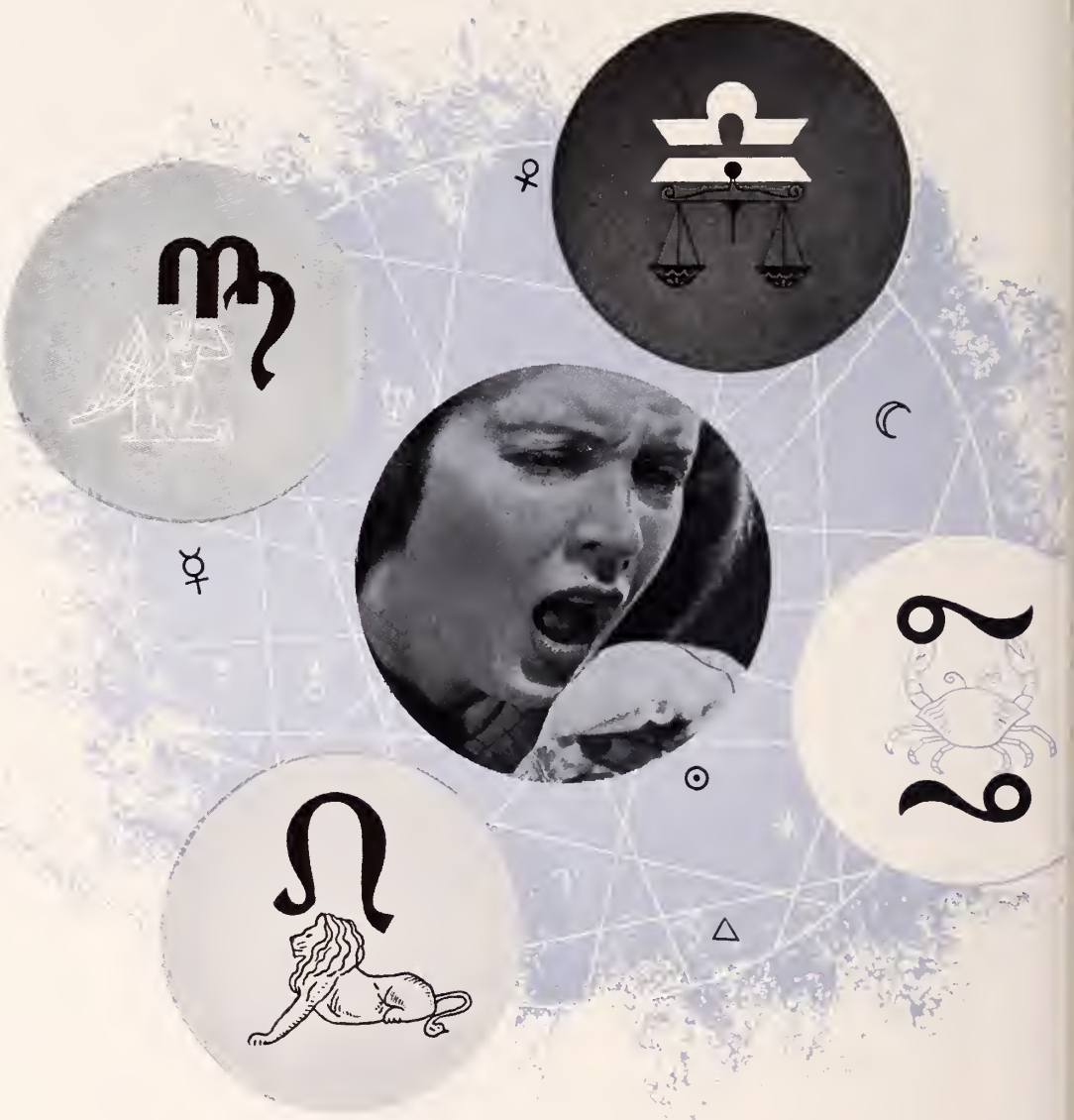

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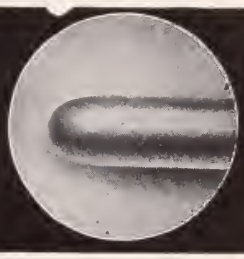

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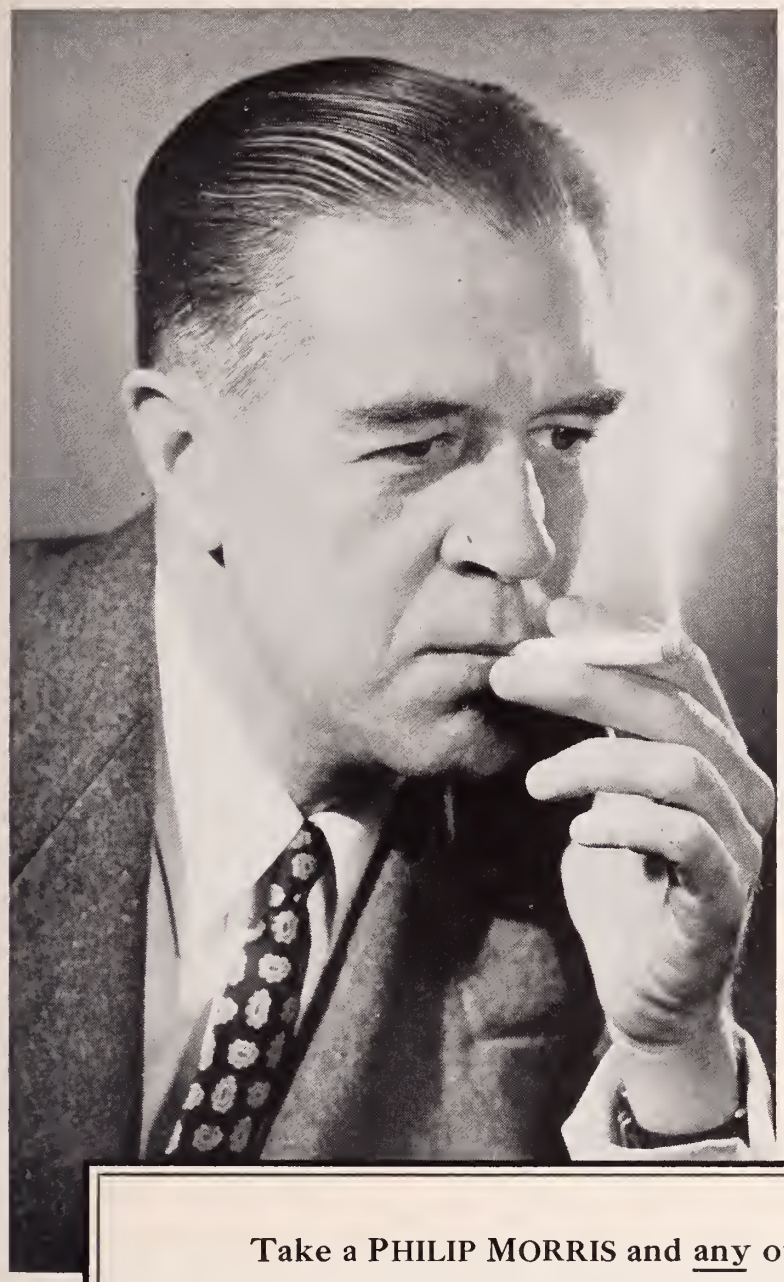

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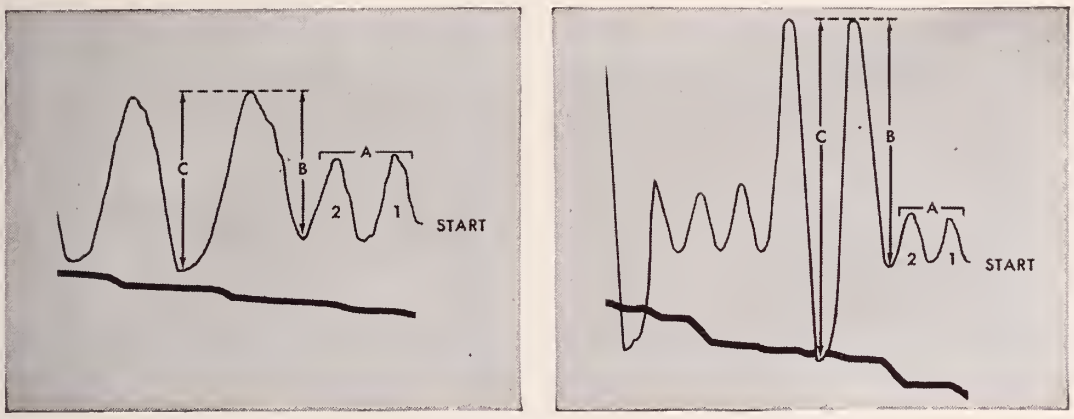

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Schwartz, E., *J.A.M.A.* **147**: 1734–1737. Dec. 29, 1951.

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1. *Perloff, Wm. H. (1951), Treatment of the Menopause. II. American J. Obst. & Gynec., 61:670, March.* **2.** *Reich, W. J., et al. (1951), A Recent Advance in Estrogen Therapy. I. American J. Obst. & Gynec., 62-427, August.*

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« « « EDITORIALS » » »

Scientific Advances, Specialization, and Public Relations*

A survey of the therapeutic discoveries of the past 30 years, the developments in diagnostic measures, the improvements in laboratory methods especially in bacteriology, chemistry, and pharmacology, readily show why more specialists are necessary.

The rise in specialization is the product of the extraordinary advances made in the fundamental sciences. As the pure scientist introduced the results of research work, the challenge of applying the new ideas to the sick and of evaluating the results was made to the physician. The medical profession has responded by acquiring each year an ever increasing number of physicians highly trained in the application of therapeutic principles and skilled in the evaluation of results.

This period of specialization has seen the introduction of specialty boards—a development with profound effect on medical education, the care of the patient, and on the training of interns and residents. The conviction has grown that one year's hospital experience after graduation is not enough to make the medical student of today highly qualified for practice. In many hospitals certification by a specialty board is a requirement for staff appointment. The number of physicians seeking residencies to qualify them for special board certification grows steadily. The positive values of this development in medical education are easily recognized. Some of its other implications are not so apparent, but they serve to remind us of the great importance of proper balance in our teaching programs. Mere certification is not an end in itself, and the young practitioner who seeks it only with thoughts of an easier life and bigger fees is in need of mature counselling.

It is my belief that the chief motive of most specialists is the comfort and consolation obtained from the more skillful management of patients, and the gratification that comes to nearly all physicians from the feeling of greater achievement in their work.

Thus, the scientific achievements of recent years in creating the need for more medical specialists are partly responsible for the rising costs of medical care. These developments and trends have had some disturbing byproducts. While the scientists who bring forth new life-giving measures and methods are, in a manner of speaking, hailed with popular acclaim, the medical profession itself has been a

*Condensed from an address given by Francis D. Murphy, M. D., at the Marquette Medical Alumni Spring Clinics in Milwaukee on March 29, 1952.

target for criticism from many different sources. In view of the esteem the public has for scientists, this apparently growing lack of regard for the physicians is rather puzzling. It is even more baffling because of the almost complete unanimity of opinion that patients of today benefit more than ever before from the advances of science and medicine. Although it is freely admitted that the physician, as a general rule, has not been the discoverer of all these benefits to mankind, yet the physician has played the prominent part in the use and application of all new methods and therapeutic agents. We will not accept the decision of some people that the doctor is merely a "dispenser" of new drugs, because in the discovery of a new remedy or method, it must be the physician at the bedside that determines the final and conclusive value of the therapeutic agent.

Undoubtedly, there are many explanations for the weakening of the bonds of feeling between the modern physician and the public. Some will say that the physician has become too impersonal, too commercial, or too selfish and unwilling to deliver the brand of service to the patients which endeared the older physicians to the family. For example, it has been said that rising generations of physicians will not make the sacrifices of night calls as frequently as some believe is necessary. Then there are some who believe that the doctor's feeling towards the individual patient has been cooler. There are some, too, who believe that the entrance of the medical profession as a whole into politics has had something to do with this disturbance.

Surveys of public opinion on several occasions have shown that the majority of patients have full confidence and deep regard for their own individual physician, but, on the other hand, have little confidence or little or no regard for the profession as a whole. The unpopularity of the medical profession makes the physician bear the brunt of complaints about the high cost of sickness. This is not justified, for it must be remembered that his fee is only part of the total expense. Various cost of living analyses indicate that doctors' fees and physicians' incomes have not gone up in proportion to the costs of hospitalization, medicines, special diagnostic services, and sick room supplies, or in fact to the price indexes generally.

Another explanation for the loosening of the bonds between the doctor and the patient is that more attention is being devoted to the disease itself, to methods of diagnosis, and to agents of treatment than to the individual himself. Formerly, patients were studied and treated more personally because the physician had to rely on inspection, palpation, percussion, auscultation, and careful interrogation and observation of the patient. Now we must admit that diagnostic machinery and impersonal devices have begun to take too prominent a place in the management of patients. This need not, and should not, occur. The use of any special laboratory technic begins at the bedside. I can easily understand that the patient as an individual seems to be taking a place of secondary importance to his disease. I should like to emphasize that I am not placing less emphasis upon the disease, its diagnosis, and treatment, but I wish to emphasize there is also a need for more careful attention to the patient as an individual. Perhaps teachers have been lax in emphasizing the importance of this factor. I am sure that interns, residents, and staff members, as well as practicing physicians, would take heed of such lessons if they came from the prominent educational centers and medical schools.

To blame the public and complain about their spending a great deal of money for other things and begrudgingly spending money for medical service does not answer the question. To understand the public's attitude and to try earnestly and honestly to correct the problem is the only way to meet the situation.

Help for the Patient with Visual Defects

From time to time physicians are confronted with problems of patients with impaired eyesight who obviously could benefit from services provided through state agencies. What those services are and where they can be secured is occasionally not understood fully by the physician who is in a position to advise his patient and give him the help needed for proper rehabilitation and adjustment to his changed mode of life. Recognizing the need for help to physicians confronted with situations of this character, the Committee on Visual Defects has published in this issue of the Journal a condensed guide which we hope the reader will detach and keep on file for ready reference. Also included are two report forms which should be used so the Division of Public Assistance will be in a position to determine which of the state agencies is best prepared to assist the particular patient referred. Additional forms are available through the office of the State Medical Society.

There may be persons known to you who are experiencing progressive sight loss with resulting detachment from normal social contacts. The Committee on Visual Defects urges that you exercise your professional influence in helping these persons to seek help which will provide them with assistance in the many adjustments necessary. To neglect this is to encourage further withdrawal of the patient and more complications for proper rehabilitation.

It should be noted that the report form stresses the importance of having the patient aware of the referral. To do otherwise will result in needless resentment and resistance to efforts made by state agencies.

The sincere cooperation of all physicians in this project is urged. By early contacts with persons in need of state services much can be accomplished which will be lost through neglect and further withdrawal of the person who becomes excessively sensitive to his handicap.—JOHN HITZ, M. D., *Chairman, Committee on Visual Defects.*

Comments from the Wisconsin Press

Medical—News Meetings

"The Wisconsin Medical Society has announced plans for a series of regional conferences to 'improve the working relationship between physicians and news reporters so that medical news can be reported accurately.'

"Meetings are planned at Sheboygan, Madison, Appleton, Wausau, Milwaukee, La Crosse and Superior, with the conference at Sheboygan today opening the series.

"Newspapermen often find it difficult to find out about the condition of persons hospitalized or in accidents; doctors and hospitals are frequently hesitant or evasive, probably partly because of their confidential relationship with the patient; then too, there are laws which forbid the release of information about a person's health unless the patient gives his consent.

"To add to the difficulties, the doctors sometimes fail to appreciate the time element and urgency in newsgathering; now and then the reporter is tactless and demanding in his dealings with busy physicians and surgeons.

"In combination, all this has made for an unhappy situation. Doctors have been unnecessarily disturbed and offended; newsmen have became disgusted with their inability to locate the doctor or the latter's inclination to be non-committal. Actually, the chief losers have been the wide public reading audience that has had to put up with sketchy or incomplete news accounts.

"Dr. A. H. Heidner of West Bend, president of the State Medical Society, says that the series of conferences in Wisconsin are designed to 'enable both (medical men and journalists) to do a better job of informing and protecting the public in health matters.'

"We are glad to see the Medical Society take this step. It is one that should help bring understanding where there has been misunderstanding between medicine and journalism."—SHAWANO EVENING LEADER, May 1, 1952.

* * *

Invitation to Discussion

"We received a very cordial invitation from the Pierce–St. Croix and State Medical Society of Wisconsin to attend a Medical—Press Conference to be held at La Crosse on Thursday, June 19th. The conference is called to help the working press in its job of presenting medical views. We want to thank the boys for the invitation, apparently, there is some shoe that's pinching, they want to get something across, but why come to the country press in which they prohibit their members from advertising—or maybe the osteopaths are beginning to cut in on their profits as the Missouri society admitted—be that as it may, we feel they should get their free publicity at the same place they spend their advertising dollar."—HAMMOND NEWS, June 12, 1952.

* * *

Doctors and Newsmen Thresh Out Problems

"The problem of handling hospital news, one which has long vexed both newspapermen and members of the medical profession, was given a thorough airing Thursday night at La Crosse, where it was discovered that the problem was not as great as it seemed.

"The occasion was a meeting called by the State Medical Society for doctors, hospital administrators, and newspaper and radio men. Both sides of the question were first presented by a representative of each group, and the session was then thrown open for general discussion.

"The question of medical ethics, which are often little understood by the layman, predominated the thinking of the medical profession. The question of the public's right to information was just as vigorously advanced by the newsmen.

"As is usual at such meetings, some newsmen insisted on demanding the maximum and some doctors insisted on giving the minimum. But the majority seemed to have resolved a bothersome problem over the conference table.

"Why such meetings were not arranged long ago is a mystery, for years of acrimonious debate could have been avoided had a middle course been adopted earlier.

"The conference proved one fact conclusively—that no problem is insurmountable if the parties concerned will sit down together and talk it over without rancor. There is no doubt that, regardless of the eventual outcome of this particular meeting, both groups now understand each other better. Doctors now know why newspapers want news quickly, and newspapermen know why doctors are reluctant to give it.

"The State Medical Society is to be complimented for inaugurating the meetings, several of which will be held throughout the state. There is no doubt but that both groups and the public as well will benefit greatly."—EAU CLAIRE LEADER, June 22, 1952.

Roentgen Therapy in Pituitary Adenomas*

With Special Consideration of the Chromophobe Type

By H. M. AITKEN, M. D. and E. A. POHLE, M. D., Ph. D.

Resident in Radiology Professor of Radiology

Madison

Introduction

THIS report is based on a study of 56 patients having pituitary tumors who were seen at the State of Wisconsin General Hospital between 1936 and 1951. Our present knowledge of these neoplasms and their radiologic management has been so well summarized by Morgan[6] that further review of the literature is not considered necessary. However, a brief review of the anatomy, physiology and pathology of the pituitary gland will be presented.

Anatomy

The anatomy of the pituitary gland is shown diagrammatically in figure 1. The posterior lobe or neurohypophysis is derived from the floor of the midbrain. The anterior lobe or adenohypophysis is formed from an evagination of the primitive buccal mucosa called Rathke's pouch. The stalk is com-

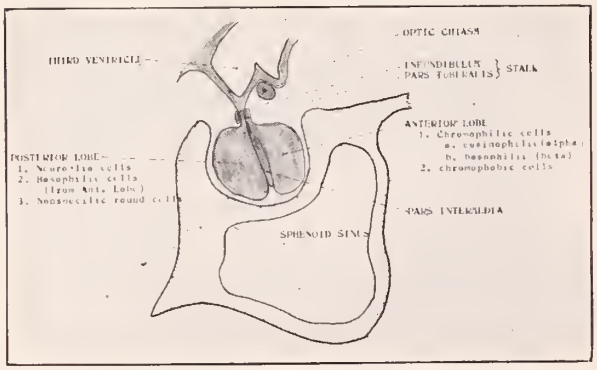

Fig. 1.—Pituitary Gland (Diagrammatic)

posed of parts from both lobes while the middle lobe, or pars intermedia, is a modification of the anterior lobe. Histologically, the anterior lobe consists of three types of epithelioid cells named according to their staining characteristics. Those taking little or no stain are the chromophobe cells or neutrophils. The other two are chromophilic and are designated "eosinophilic" or "basophilic" depending upon their staining qualities. Instead of "eosinophilic" some authors prefer the word "acidophilic."

The posterior lobe is made up of a framework of neurogenic tissue or neuroglia in which are embedded basophilic cells believed to have migrated from the anterior lobe. In addition, a large, round, non-specific cell is present, the origin of which is uncertain.

The pars tuberalis is an upward extension of the anterior lobe and it, along with the neural infundibulum, constitutes the pituitary stalk. It is in the region of the pars tuberalis that many craniopharyngiomas arise.

Physiology

The physiology of the hypophysis is complex and not fully understood.[3] Attempts have been made to ascribe specific functions to each of the cell types present in the gland, but this has been only partly successful. Much of our present knowledge has been obtained by correlating antemortem clinical evidence with postmortem findings. Study of hypophysectomized laboratory animals has also been of much value. In general, the known functions of the anterior and posterior lobe cells are shown in table 1.

From the basophilic cells are derived the gonadotrophic substances which influence the hormonal activities of the ovary and testis. FSH, or follicle-stimulating hormone, is the stimulator of the ovarian follicle which in turn produces the estrogens. In the male, FSH induces sperm production. LH is the luteinizing hormone which causes ovulation and the subsequent development of the corpus luteum. In the male, LH stimulates the production of testosterone. The lactogenic hormone initiates milk production in the female.

ACTH, or adrenocorticotrophic hormone, is discussed widely in the current medical literature and rightly so, because it is now apparent that this hormone, along with those secreted by the adrenal cortex, have a profound influence on many of the vital functions of the body both in health and dis-

TABLE 1.—*Pituitary Physiology*

I. *Anterior Lobe*
- A. Basophilic Cells
  - 1. Gonadotrophic Hormones
    - (a) Follicle-stimulating hormone
    - (b) Luteinizing hormone
  - 2. Lactogenic Hormone
  - 3. ACTH—(Adrenocorticotrophic Hormone) ↓↑ Adrenal Cortex
    - (a) salt hormone
    - (b) androgenic hormone
    - (c) corticoid substances
- B. Eosinophilic Cells
  - 1. Anti-insulin factor
  - 2. Thyrotropic hormone
  - 3. Growth hormone
- C. Chromophobe Cells
  - 1. Non-secretory

II. *Posterior Lobe*
- 1. Vasopressor hormone
- 2. Anti-diuretic hormone
- 3. Oxytocic hormone

*From the Department of Radiology, University of Wisconsin Medical School.

ease. Removal of the anterior lobe of the pituitary causes an atrophy of the adrenal cortex. On the other hand, pituitary hyperfunction, such as is seen in acromegaly, is accompanied by hypertrophy of the adrenal cortex. Conversely, parenteral administration of exogenous cortisone depresses ACTH production. This reciprocal relation between the corticoid substances from the adrenals and ACTH from the hypophysis is still under intensive investigation and much remains to be elucidated. At present it is known that the administration of ACTH to *normal* humans has the following effects:

1. Increased excretion of nitrogen, potassium, and phosphorus.
2. Retention of sodium and chloride ions and secondary retention of water.
3. Elevation of the fasting blood sugar and production of a diabetic glucose tolerance curve.
4. Increased excretion of uric acid.
5. Decline in circulating eosinophils and lymphocytes and elevation of polymorphonuclear leukocytes.

The eosinophilic cells of the anterior lobe are known to secrete three hormones. The anti-insulin or diabetogenic factor inhibits the action of insulin so that when this factor is present in excess, a diabetic state appears which is not pancreatic in origin. The thyrotropic hormone is the stimulator of the thyroid gland and when decreased or absent produces a cretin-like state similar to that resulting from a primary deficiency of the thyroid hormone itself. The reverse is also true, that is, hyperthyroidism develops when the thyrotropic hormone is present in excess. The growth hormone stimulates the growth of the long bones at the epiphyses as well as the growth of soft tissue. If the hormone is present in excess before the epiphyses close, giantism results, whereas acromegaly appears if the excessive stimulation occurs after closure of the epiphyses. Complete absence of the hormone results in cessation of all growth as seen in the pituitary dwarf.

The chromophobic cells are thought to be the precursors of the chromophilic cells and have no known secretory function.

The posterior lobe cells secrete three hormones:

1. The vasopressor hormone, which contracts the blood vessels and raises blood pressure.
2. The oxytocic hormone which contracts smooth muscle, particularly that of the uterus.
3. The antidiuretic hormone, lack of which results in the condition known as diabetes insipidus.

Pathology

Neoplasms of the hypophysis[5] are divided into three groups: adenomas, craniopharyngiomas, and miscellaneous rare tumors as shown in table 2.

1. *Adenomas*—According to Bailey[1] these tumors comprise 17.8 per cent of all intracranial tumors and 70 per cent of the pituitary tumors. They may be benign or malignant and are of three types. Chromophobic and eosinophilic adenomas arise almost exclusively in the anterior lobe, but basophilic tumors are found equally in either lobe. Symptoms are the result of pressure on nearby structures, disturbances of endocrine function, or both. In some instances the tumor may be of a mixed type in which case the clinical picture may be extremely bizarre. The malignant adenomas rarely metastasize.

TABLE 2.—*Pituitary Tumors (Classification)*

I. *Adenomas*
A. Chromophobe Adenomas
1. Symptoms result from pressure
a. visual disturbances
b. hypopituitarism
c. headache
B. Basophilic Adenomas
1. Symptoms mainly those of metabolic and gonadal dysfunction
a. Cushing's syndrome (?)
b. truncal obesity
c. hyposexuality
C. Eosinophilic (acidophilic) Adenomas
1. Symptoms mainly those of disturbances in growth, i.e., giantism, acromegaly, dwarfism
II. *Craniopharyngiomas*
1. Symptoms result from pressure either intrasellar or suprasellar
2. 50 to 70 per cent show calcification on x-ray film
III. *Miscellaneous* (rare)
1. Fibromas—fibrosarcomas
2. Angiomas
3. Chordomas
4. Teratomas

The chromophobe adenomas cause symptoms by pressure on adjacent structures, often on the optic chiasm, hence the frequency of visual disturbances. In addition, these tumors may produce secondary pressure atrophy or necrosis of the rest of the gland resulting in hypopituitarism. The basophilic adenomas are frequently quite small, but the excess hormones they secrete may be responsible for profound constitutional changes. Formerly, it was thought that Cushing's syndrome was caused by these tumors, but now there is considerable evidence that other glands, particularly the adrenals, may also be the primary site of disease and that the changes seen in the pituitary are secondary. Furthermore, it has been shown that basophilic adenomas may occur without any clinical symptoms. The acidophilic adenomas first produce disturbances in growth, but as they expand, symptoms of hypopituitarism may appear secondary to pressure atrophy of the gland.

2. *Craniopharyngiomas*—These account for 4.5 per cent of all intracranial tumors and about 30 per cent of hypophyseal tumors.[1] They arise from squamous epithelial cell-rests which are remnants of the craniopharyngeal canal or Rathke's pouch. They occur more frequently as a disease of the young and may be benign or malignant. They may be intra- or suprasellar in position, usually the latter. Histologically they consist of nests of squamous cells in a fibrous stroma. Frequently the center of these cell masses becomes necrotic with cyst formation and subsequent calcification. Craniopharyngiomas often show a strong resemblance to adamantinomas.

TABLE 3.—*X-Ray Dosage (Illustrative cases)*

Case No.	Tumor	Total r (air) per field. (No of fields)	No. of Series	Interval between series	Results	
					Improved	Not improved
1.	Basophilic (?)	3,300 (3)	5	various 1937-41		X
2.	Acidophilic	2,800 (3)	2	10 months		X
3.	Acidophilic	900 (3)	1		X	
21.	Acidophilic	1,200 (3)	2	4 months	X	
5.	Chromophobe	1,200 (3)	1		X	
10.	Chromophobe	900 (3)	1		X	
14.	Chromophobe (cystic)	1,200 (3)	1			X
16.	Craniopharyngioma	3,450 (3)	4	4 months		X (died p.o.)

3. Other primary tumors of the pituitary, which are quite rare, are shown in table 2.

Technic of Treatment

In our clinic most cases of pituitary tumors are treated with an x-ray beam generated at 175 kilovolts filtered through 0.5 mm. of copper plus 1.0 mm. of aluminum; the half value layer is 1.05 mm. of copper. The tumor area is cross fired through one frontal and two temporal fields measuring 4 by 4 cm. or 6 by 6 cm. The target skin distance is 50 cm. Ordinarily 100 to 200 r, measured in air, are administered daily to each of the three fields until a total tumor dose of between 2,000 and 3,000 r has been delivered. However, this dosage is subject to considerable variation depending largely upon the reaction of the patient. The first two or three treatments are given cautiously and in reduced amounts to avoid the possibility of suddenly increasing the intracranial pressure through radiation hyperemia. As an added precaution, the visual fields are checked frequently by an ophthalmologist during treatment, and any pronounced contraction of them is an indication to suspend or reduce treatment at once. If the field contraction persists or increases, immediate surgical intervention is indicated to relieve the pressure on the optic tracts. Until recently it was customary to administer a series of six to eight daily treatments and then repeat the series at intervals varying from one to several months. At present, however, our policy is to continue treatment without interruption until the desired tumor dose has been reached. Kerr's[4] technic is quite similar to ours with the exception that he adds a fourth vertical cranial field. It is noteworthy that the present day tumor dose of about 2,500 r is in striking contrast to approximately 600 r which was considered maximum 30 years ago. Table 3 illustrates the wide variation in dose among our patients.

Report of Cases

In our group of 36 cases of pituitary tumors there were 19 males and 17 females. The oldest patient was 71 years, the youngest 21, and the average 43 years old. In 14 cases there was histologic proof of the presence of the tumor obtained either from a biopsy or postmortem specimen. The incidence of the tumor types among these 14 proved cases is shown in table 4. Table 5 shows the distribution of tumor types among the remaining 22 unproved cases in which the diagnosis was based on clinical and/or roentgenologic evidence.

As noted previously the signs and symptoms of pituitary tumors vary considerably and are sometimes bizarre. In this study no attempt has been made to ascribe any symptom or group of symptoms to a specific type of tumor. Instead they have been listed in the order of frequency of occurrence as shown in table 6. Thus, impaired vision and headache are by far the most common complaints, and when they are accompanied by mental or personality changes, weakness, enlargement of the face or extremities, somnolence, or obesity should arouse a suspicion of pituitary tumor at once. A perusal of the histories of our cases shows that all too often middle aged patients with visual complaints were

TABLE 4.—*Pituitary Tumors, Proved Cases*

Chromophobe adenomas	7
Malignant adenomas (not otherwise classified)	5
Craniopharyngioma	1
Adamantinoma	1
Total	14

TABLE 5.—*Pituitary Tumors, Cases Diagnosed Clinically*

1. Chromophobe adenomas	12
2. Eosinophilic adenomas	8
3. Basophilic adenoma	1
4. Type undetermined	1
Total	22

TABLE 6.—*Pituitary Tumors, 36 cases*

Common Symptoms	Frequency Order
1. Impaired vision	20
2. Headache	19
3. Mental changes	6
4. Weakness	5
5. Enlarged extremities and face	5
6. Obesity	4
7. Somnolence	4
8. Amenorrhea	3
9. Vomiting	3
10. Frigidity or impotence	2
11. Hirsutism	1
12. Polyuria	1
13. Polydypsia	1
14. Nervousness	1
15. Convulsions	1

treated for many months before the true etiology was discovered or even suspected.

In general, the physical signs found were those resulting from pressure of the tumor on adjacent structures and/or disturbances in endocrine function. Their incidence and order of occurrence are shown in table 7.

TABLE 7.—*Pituitary Tumors, 36 cases*

Common Physical Signs	Frequency Order
1. Visual field defects	22
2. Truncal obesity	12
3. Acromegaly	10
4. Optic atrophy	7
5. Hypertension	5
6. Hypertrichosis	2
7. Cranial nerve involvement	1
8. Papilledema	1

The roentgen signs of pituitary tumors are enlargement and/or erosion of the sella turcica, demonstration of the presence of a suprasellar mass, either by plain or stereoscopic films or encephalography and the presence of the typical bone changes of acromegaly. These latter are sometimes present in the absence of the intracranial findings, and in such cases we feel that the diagnosis of pituitary tumor is justified. From 50 to 70 per cent of all craniopharyngiomas contain sufficient calcium to produce a visible shadow in the roentgenogram, particularly if cystic degeneration has occurred. In our one proved case of craniopharyngioma, no calcification within the tumor could be demonstrated in spite of the fact that operation proved it to be quite cystic.

For purposes of evaluation of treatment the cases have been divided into three categories: (1) proved cases, (2) cases treated by x-rays only, on the basis of clinical and roentgenologic evidence, and (3) untreated cases (table 8).

TABLE 8.—*Pituitary Tumors, Treatment Classification*

I. Proved Cases	14
A. Cases treated by operation only	3
B. Cases treated by x-rays plus operation	11
II. Cases treated by x-rays only (Diagnosis made by x-ray and clinical evidence)	17
III. Untreated cases	5
Total	36

Of the 14 proved cases, 3 died within the postoperative period and did not receive x-ray therapy. Two of these had adenocarcinomas and one an adamantinoma. The remaining 11 cases in this group were treated with a combination of operation and x-rays and are subdivided into those receiving preoperative and postoperative irradiation. Table 8–A briefly summarizes data on four patients who received x-ray therapy for periods varying from 3 to 12 months *before* operation with unsatisfactory results. At operation the first 2 of these 4 patients were found to have cystic tumors and the third had an adenocarcinoma. All 3 subsequently died. The fourth case had a cystic adenoma and was markedly improved following operation. These 4 cases are significant because they confirm observations of others[2,4] that failure of a patient to improve within two to four months after adequate x-ray treatment is probably an indication for surgical intervention.

TABLE 8–A.—*Proved Cases Treated Preoperatively*

Case 15—*Acidophilic Adenoma*-cystic. Died following second craniotomy.
Case 16—*Craniopharyngioma*-cystic. Died 2 years later of recurrence.
Case 23—*Adenocarcinoma.* Died in postoperative period.
Case 14—*Chromophobe Adenoma*—cystic. Did well postoperatively.

The results in the 7 cases which received postoperative irradiation are shown in table 8–B. Six had chromophobe adenomas and one an adenocarcinoma. All of them were improved when last seen except for case 4. In this instance postoperative x-ray treatment produced only temporary improvement. The patient subsequently became psychotic and had to be confined. Case 5 was that of a cystic chromophobe adenoma; this patient did well for five years following partial surgical removal. Symptoms then recurred and x-ray therapy was used in lieu of a second operation, in spite of the fact that the tumor was known to be cystic. The response was considered satisfactory since no further loss of vision occurred, and the headaches were controlled. However, the follow-up period of six months is too short for final evaluation. In case 9 immediate postoperative x-ray treatment was given, and when last seen six months later the patient was definitely improved. Case 18 is a duplicate of case 9. The patient was considered improved when last seen six months later. In case 19 the patient had a recurrence of symptoms three years after operation, but these were well controlled by a course of x-ray therapy, and no further treatment was required during the next three years. In case 20 the follow-up is too short for evaluation but the presence of the malignant tumor, of course, makes the prognosis unfavorable. Case 22 has had almost complete relief of symptoms for four years following combined operation and postoperative irradiation.

TABLE 8–B.—*Proved Cases Treated Postoperatively*

Indication For X-ray Therapy	Result
Case 4 Relapse 5 years p.o. (chromophobe adenoma)	Improved temporarily. Later psychotic.
Case 5 Relapse 5 years p.o. (cystic chromophobe adenoma)	Good. Five months follow-up.
Case 9 Partial resection of tumor (chromophobe adenoma)	Improved. Six months follow-up.
Case 18 Elective (chromophobe adenoma)	Good. Nine months follow-up.
Case 19 Relapse 3 years p.o. (chromophobe adenoma)	Good. Three year follow-up.
Case 20 Adenocarcinoma	?. Six months follow-up.
Case 22 Partial resection of tumor. (Chromophobe adenoma)	Good. Four year follow-up.

TABLE 9.—*Seventeen Cases Treated by X-rays Only*

Case No.	Tumor	Total r (in air) to each field. (No. of fields)	Results		Period of Observation	Remarks
			Improved	Not improved		
1	Basophilic (?)	3,300 (3)		X	5 yr.	Clinical diagnosis only
3	Acidophilic	900 (3)	X		15 yr.	Headaches subsided
7	Acidophilic	1,200 (3)	X		9 yr.	Sella recalcified
8	Acidophilic	1,080 (4)	X		1 yr. 7 mo.	Disease arrested
21	Acidophilic	1,200 (3)	X		5 yr. 9 mo.	Bone enlargement arrested
2	Acidophilic	2,800 (3)		X	5 yr. 6 mo.	No improvement
6	Acidophilic	3,370 (3)		X	1 yr. 10 mo.	Failed to return
24	Acidophilic	1,800 (3)		X	1 yr. 7 mo.	Had temporary relief only
11	Acidophilic	1,050 (3)				No follow up
34	Chromophobe	1,800 (3)	X		2 yr. 6 mo.	Visual fields became normal
10	Chromophobe	900 (3)	X		3 yr. 5 mo.	Visual fields became normal
12	Chromophobe	900 (3)	X		5 yr.	Disease considered arrested
13	Chromophobe	1,200 (3)	X		7 mo.	Disease considered arrested
25	Chromophobe	1,200 (3)	X		3 yr.	Disease considered arrested
28	Chromophobe	2,400 (3)	X		5 yr.	Sellar erosion halted
17	Chromophobe	1,600 (3)	?		2 yr.	Symptoms persisted but could work
35	Chromophobe	1,800 (3)				Follow up too short

Table 9 is a summary of the 17 patients treated with x-rays only. Case 1 is of interest since it is our only patient showing Cushing's syndrome.* The diagnosis was based on the clinical findings of truncal obesity, hypertrichosis, hypertension, headache, and mental depression. The visual fields were normal, but there was equivocal enlargement of the blind spots. X-ray films of the skull showed very questionable enlargement of the sella. Between 1937 and 1941 this patient received a total of 3,300 r (in air) to each of three cranial fields but without significant benefit. In retrospect the question arises as to whether or not the adrenals were the primary site of disease. If so, it might be worth while, in such cases, to consider x-ray therapy of the adrenals.

Of the remaining 16 patients in this group, 8 had chromophobe adenomas and 8 acidophilic adenomas. Of those having acidophilic tumors only 4 patients, on whom we have adequate follow-up, obtained good results from treatment whereas 6 of those having chromophobe tumors were definitely improved.

In the group with acidophilic tumors which improved, case 3 is noteworthy since he was under observation for nine years before receiving x-ray therapy in 1945. Since that time his headaches have completely subsided, and there has been no further progression of his mild acromegaly. In case 7 the previously eroded and porotic sella recalcified completely. Patient 8 was a typical acromegalic case when first seen. Following treatment the subjective complaints regressed, and the objective signs remained stationary. Patient 21 was also an acromegalic case but with the bone changes confined to the extremities and jaw. Here again there was subjective and objective improvement following treatment. The reason cases 2, 6, and 24 failed to improve is not known. They were all frankly acromegalic cases and as far as could be determined differed in no essential feature from those patients who did improve under treatment.

Among the patients having chromophobe tumors, case 34 is one of the most dramatic. When first seen at the hospital, this 55 year old woman had had progressive failure of vision during the previous three years. A complete bitemporal hemianopsia was present, and the encephalogram showed an uncalcified suprasellar tumor mass 2.5 cm. in diameter. The sella itself was only questionably enlarged. Following the administration of 1,800 r to each of three cranial fields, there was prompt and progressive improvement. When last seen two and one-half years later her visual fields were entirely normal and her headaches had disappeared. Patient 10 also regained normal vision, but in this case the degree of original impairment was much less. Cases 12, 13, 25, and 28 all had well developed signs and symptoms before treatment, and in each instance progression of the disease was halted, and clinically the results of treatment were considered satisfactory.

The efficacy of treatment in cases 17 and 35 is in doubt. Patient 17 had the unusual chief complaint of epileptiform convulsions. However, skull films showed an enlarged and eroded sella indicating the presence of a chromophobe adenoma. He was not seen following x-ray therapy but two years later wrote us that he was working daily in spite of the fact that he was still having seizures. Case 35 is our most recently treated patient and has not been followed long enough to evaluate results.

Finally, 5 of the 36 patients received no treatment of any kind for various reasons, such as: symptoms considered too mild, left hospital against advice, etc.

Summary

1. An analysis of 36 cases of pituitary tumors observed at the State of Wisconsin General Hospital between 1936 and 1951 is presented.

*An additional proved case of basophilism followed 11 years and treated both surgically and by x-rays has been reported previously by Pohle and Weissman in Annals of Internal Medicine, 32: 542–548 (March) 1950.

2. The anatomy, physiology, and pathology are briefly discussed; our technic of x-ray therapy is outlined.

3. In our opinion, x-ray therapy has a definite place in the treatment of pituitary tumors, especially postoperatively in those with incomplete removal of the tumor, but also in some cases as a single therapeutic agent.

4. The concept of the high radioresistance of all chromophobe adenomas should be revised in the light of more recent experience. As we have shown, satisfactory response may be expected in these cases provided sufficiently high doses are administered.

(E. A. P.) 1300 University Avenue.

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MILWAUKEE ACADEMY OF MEDICINE SPONSORS ESSAY CONTESTS

Two essay contests are being sponsored by the Milwaukee Academy of Medicine again this year—the Horace Manchester Brown Memorial Prize Essay Contest and the Rogers Memorial Prize Essay Contest, the latter founded by the Rogers Memorial Sanitarium of Oconomowoc.

In the Horace Manchester Brown Memorial contest, the Academy offers prizes of $100 and $50 for the two best scientific essays in any field of medicine, surgery, or the allied specialties. The essays need not represent original investigation but should represent individual work and must not have been previously published.

The contest is open to all physicians who have been graduated from medical school within the past ten years and who are residing in the state of Wisconsin or who are in the Armed Forces at the time the essay is submitted. Physicians who have been discharged from the Armed Forces and who have been graduated for more than ten years may submit essays if deduction of their period of service will bring them within the above mentioned ten year period following graduation. Awards will be determined by judges selected by the committee and will be presented at the annual meeting of the Academy of Medicine. Winning essays will be read at subsequent meetings.

Prizes of $200 and $100 will be offered in the Rogers Memorial contest, for the two most meritorious studies in the fields of neurology, psychiatry, and psychosomatic medicine. The contest is open to all members of the medical profession who are citizens of the state of Wisconsin, whether they are actually in residency or not, and to those who, not ordinarily residents of the state, are stationed in Wisconsin in the Armed Forces. Awards will be determined by judges selected by the committee and will be presented at the annual meeting of the Academy of Medicine. Winning essays may be read at subsequent Academy meetings and must be placed on file in the library of the Rogers Memorial Sanitarium, but may be submitted for publication (with proper acknowledgment) at the discretion of the author or the Rogers Memorial Sanitarium.

In both contests, all papers must be submitted in triplicate and double spaced. They should be sent to the office of the Milwaukee Academy of Medicine, 561 North Fifteenth Street, Milwaukee 3, Wisconsin, not later than December 1. The committee reserves the right to withhold the awarding of prizes if in its judgment no papers worthy of award have been submitted.

Secondary Abdominal Pregnancy of Five Months' Duration Terminated by Laparotomy

By J. A. KLIEGER, M. D.* and J. R. EVRARD, M. D.*
Milwaukee

ABDOMINAL pregnancy is uncommon and rarely does one proceed to the stage of viability: It occurs once in each 10,000 pregnancies, according to Dorman. The treatment is fairly well standardized and usually offers no great problem. Its recognition is difficult in most instances, not only because of its rarity, but also because of the obscure nature of the clinical picture. We are submitting the following case report mainly because of its unusual diagnostic features.

The patient, Mrs. C. B. (Case No. 9319), a 25 year old white gravida II, para 0, who had had one cesarean section, entered the hospital on Aug. 30, 1950, with the chief complaint of vaginal spotting for two days. The bleeding was minimal and the patient had no cramps. Her last normal menstrual period had been May 10, 1950, and up to the present illness the pregnancy had been uneventful. A nontender mass was felt just above the symphysis and was assumed to be the uterus. The blood count was normal. A diagnosis of threatened abortion was made. The patient was kept in bed and was given sedation and intramuscular progesterone. The symptoms subsided and the patient went home on Sept. 2, 1950.

She re-entered the hospital on Dec. 9, 1950 and was first seen by the authors at this time. She complained of lower abdominal pain and intermittent spotting since her previous hospitalization. The red blood count had dropped to 2,400,000 and the hemoglobin to 52 per cent. Her skin was pallid and a tumor, difficult to outline, was felt in the lower left quadrant. A maternal souffle was heard in this area, but no fetal heart tones were audible. A flat plate of the abdomen (figure 1) showed a single pregnancy of about 5½ months gestation with collapse of the skull bones and angulation of the spinal column. The fetus appeared displaced to the left side of the abdomen and was apparently dead. The patient received several transfusions.

On December 15 Lipiodol was injected into the cervix and the following x-ray (figure 2) showed a collection of opaque media triangular in outline. The oil in the uterine cavity appeared anterior to the fetal skull as shown in figure 3. A 24 hour film showed no opaque media in the peritoneal cavity. On the clinical and x-ray findings, a tentative diag-

Fig. 1—Flat plate of abdomen illustrating the collapsed cranial bones of a fetus displaced to the left side of the abdomen.

Fig. 2—Lipiodol injection into the cervix showing uterine cavity superimposed over the head of the fetus.

*From the Department of Obstetrics of Marquette University and St. Joseph Hospital, Milwaukee.

The authors wish to express their gratitude to Mr. Leo C. Massopust of the photographic department of Marquette University School of Medicine for supplying the illustrations.

Fig. 3—Oblique view of pelvis and abdomen after lipiodol injection into cervix. Fetal skull appears posterior to the uterine cavity.

nosis of extrauterine pregnancy was made, and laparotomy was performed on Dec. 17, 1950.

The abdomen was opened through a lower midline incision. The uterus was 1½ times normal size, and the left tube and ovary were not grossly remarkable. The right tube was distended to the size of a grapefruit. On the fimbriated end of the tube was a large placenta, 75 per cent of which was attached to endosalpinx and 25 per cent of which was adherent to the peritoneum of the right iliac fossa. The umbilical cord extended upward medially into a mass of adhesions which involved small bowel, omentum, and parietal peritoneum. Then the cord extended to the fetus on the left side. The fetus measured 26 cm. crown to rump, and was macerated and adherent to several loops of small bowel.

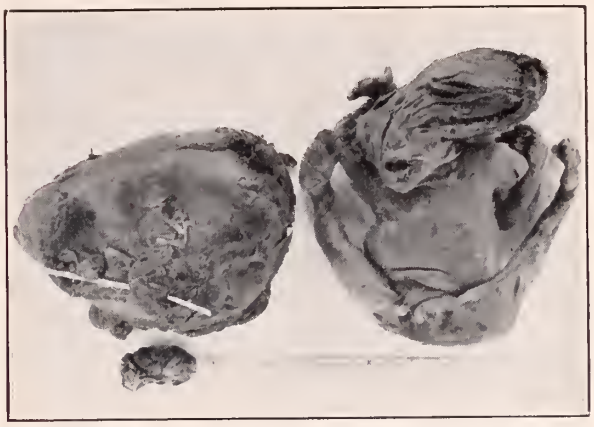

Fig. 4—Surgical specimen of the portion of the placenta and tube which was recovered and the macerated fetus. Probe has been passed through the lumen of the tube.

The right tube was amputated, but the portion of the placenta implanted on the peritoneum was not disturbed. The fetus and umbilical cord were carefully dissected away from the bowel and were removed except for several small areas which were firmly adherent to the ilium. Figure 4 illustrates the removed surgical specimen. The abdomen was closed in the usual fashion without a drain.

The postoperative course was uneventful, the temperature never exceeding 99.6 F. The patient was allowed to walk on the first postoperative day and after this time was afebrile. She was discharged on the seventh postoperative day. Pelvic examination six weeks later showed normal involution of the pelvic organs, and the portion of placenta left in the abdomen at the time of surgery could not be palpated.

(J.A.K.) 425 East Wisconsin Avenue.

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WISCONSIN STATE MEDICAL GOLF ASSOCIATION PLANS TOURNAMENT

The Wisconsin State Medical Golf Association has scheduled a tournament for August 21 at the Pine Hills Country Club at Sheboygan. Tee-off time will be at 1 p.m. The day's entertainment will include lunch, and following the day's golfing, a social hour and dinner.

Prizes will be awarded for low gross and low net scores; the longest drive on two tee-offs, and the closest to the pin on two greens, and the blind bogey.

Reservation blanks and announcements will be sent to the members of the State Medical Golf Association soon. Reservations should be sent to the Wisconsin State Medical Golf Association, Room 700, 208 East Wisconsin Avenue, Milwaukee 2, Wisconsin.

A Reformed Mealtime Schedule

Its Effect on Weight and Serum Glucose of Tuberculous Children*

By KARL E. KASSOWITZ, M. D.**
Milwaukee

THE problem of proper timing for the food intake of children after the first year of life has not been given much consideration in the past. There exists, no doubt, occasional maladjustment to the meal schedule at home, and the subject of anorexia on a non-organic, but functional or psychoneurotic basis, requires special attention.

The object of this study, however, is the adequacy or inadequacy of the mealtime schedule and of the intervals between meals in a children's hospital and, specifically, in a hospital ward for tuberculous children. It is obvious that this requires, particularly in chronic hospital cases, a dietary regime which provides the best possible opportunity for optimal nutritional results.

The question arises whether or not the timing of the hospital meals, as it is customarily practiced in most hospitals, sanatoria and children's institutions, proves to be in line with the requirements of the patients.

There is practically no reference to the timing of meals to be found in the literature on dietetics. Milton A. Bridges[1] has only this to say on this subject. "Both courses and meals should be spaced at suitable intervals." Harry Gauss[2] gives the following schedule for a so-called liquid and soft diet: 8 a.m., 10 a.m., 12, 3 p.m., 6 p.m., 9 p.m. Mary S. Rose[3] never mentions the possibility of a late after supper, bedtime lunch. Dr. Frances L. Ilg[4] mentions two important points in relation to the frequency of food intake. She states, "children also seem to eat better when they are given between meal snacks. If children are too hungry, they won't eat." "By ten and eleven the child thinks about food, dreams of food, and in fact likes to eat all the time."

In order to arrive at a more or less precise answer, the mealtime schedule of 40 hospital patients was first compared to the food intake patterns of different age categories.

The outstanding feature of the hospital schedule is the long interval of 15 hours between the last meal of the day at 4:30 p.m. and the breakfast of the following day at 7:30 a.m., while the three meals are crowded together into about nine hours. The ratio between the period of food intake and of the fasting interval is, in this case, $9:15 = 0.6$.

In comparison with this we have considered several significantly different meal patterns:

1. The continuous flow of prenatal food supply through the umbilical artery.

2. The interrupted but more or less regular, around-the-clock feeding during the newborn period.

3. The establishment of a fasting interval at night during early infancy from 10 p.m. to 6 a.m., which is eight hours. Ratio $16.8 = 2.0$.

4. The fasting interval is extended to 11 to 12 hours in later infancy, from 6 to 7 p.m. to 6 a.m. Eleven hour ratio: 1.2.

5. At toddler and early school age the night interval is extended from 6 to 6:30 p.m. to 7 to 7:30 a.m. Thirteen hour ratio: 0.85.

6. The average maturing or mature adolescent reduces, as a rule, the fasting interval to about nine hours, by way of a more or less substantial late lunch, at about 9 to 10 p.m., bringing the ratio up again to about 1.7.

The dietary problem confronting us in a hospital ward for active childhood tuberculosis in 40 children between the ages of 1 and 12 years is how to obtain the best possible nutritional results. To achieve this we offer, (1) a diet of proper quality, and (2) inducement for consuming the proper quantity.

In observing the actual eating performance of hospitalized children we notice that in many instances the food intake during the nine hours, three or four-meal-period falls short of the total caloric amount which appears desirable for optimal gain of weight and physical development.

In order to correct this deficiency, a bedtime lunch of between 200 and 300 calories at 8 p.m. has been introduced. This additional meal was accepted as a rule without any reluctance and in most cases consumed with great delight.

The approximate amount of calories offered the children (including 8 p.m. lunch) was 2,500 calories.

To analyze the results, we first compared the effect of the new mealtime schedule on the weight curve. There was no way of eliminating the various other factors like the extent and stage of the disease, medication and, more than anything else, the state of nutrition and the length of hospitalization, which all have a definite bearing on the progress of the weight curve.

We determined the gain of weight in 40 children over a period of three months, first on the old schedule with the long 15 hours night interval, and afterwards over a three months period with the extra meal at 8 p.m. and the shorter 11½ hours fasting period. In spite of the great variety of cases

* From the Children's Department of Muirdale Sanatorium of Milwaukee County.

** Associate Clinical Professor of Pediatrics, Marquette University Medical School.

TABLE 1—*Typical Daily Menu*

	Calories	Proteins	Fat	Carbohydrates
Breakfast	599	19	31	61
Dinner	771	30	39	75
Supper	742	25	30	93
Lunch to 2:30 p.m.	147	6	7	15
Lunch to bedtime	329	10	13	43
Daily Total	2,588	90	120	287

Recommended Dietary Allowances
National Research Council (Revised—1948)

Children	Calories	Proteins
		Gm.
4– 6 years (42 lb., 19 kg.)	1,600	50
7– 9 years (58 lb., 26 kg.)	2,000	60
10–12 years (78 lb., 35 kg.)	2,500	70

TABLE 2—*Bedtime Lunch Patterns*

	Proteins	Fat	Carbohydrates
1. 2 graham crackers	2		12
8 oz. milk	8	10	12
	10	10	24
		226 calories	
2. 8 oz. milk	8	10	12
Banana	1		22
	9	10	32
		254 calories	
3. 8 oz. milk	8	10	12
Iced cupcake	2	3	31
	10	13	43
		329 calories	
4. 8 oz. milk	8	10	12
Angel food cake	3		23
	11	10	35
		274 calories	
5. 8 oz. milk	8	10	12
Cookie (1)	1	3	18
	9	13	30
		273 calories	

TABLE 3—*Fasting Glucose Determinations*

No.	Age	Sex	15 Hour Interval	11½ Hour Interval
1	5	F	90	100
2	4	M	90	96
3	11	M	88	126
4	7	M	104	104
5	4	M	96	114
6	8	M	90	104
7	10	M	80	142
8	11	F	96	122
9	5	F	94	96
10	8	M	96	100
11	10	M	100	126
12	12	F	96	114
13	11	M	90	100
14	10	M	92	104
15	11	F	96	106
16	12	F	104	104
17	8	M	74	90
18	12	F	86	84
19	8	M	84	78
20	11	M	52	80
21	6	M	62	88
22	7	M	70	84
23	8	M	60	86
24	5	F	66	74
25	8	M	82	92
26	12	F	94	84
27	11	F	100	82
28	4	M	78	80
29	5	F	73	84
30	8	F	88	88
31	6	M	74	90
32	6	F	78	80
33	8	M	80	84
34	12	F	74	86
35	8	F	66	84
36	9	F	74	100
37	6	M	62	70
38	9	F	72	80
39	6	F	66	68
40	6	M	58	72
			3275	3456
Average			81.88	93.65

and conditions encountered, the average gain among this group in three months rose from 0.78 Kg. to 1.35 Kg.

Secondly, we compared fasting blood glucose levels in these patients after 15 hours and 11½ hours fasting night interval.

There is very little information to be found in fasting blood glucose studies because most glucose tolerance determinations are confined to periods of 180 minutes. There are several authors[5,6] who have found higher glucose values after 180 minutes in normal subjects. Whether there are different fasting serum glucose values to be found if the fasting period lasts 15, 12, or less hours seems to have been an open question up to our present study.

In analyzing the results of 80 determinations in 40 children (see table 3), we found in 4 instances a slight decrease in blood glucose values, in 3 cases absolutely identical figures, but in 33 cases a definite increase in blood glucose after the shorter night interval. The increase from an average of 81.88 mg. per 100 ml. after the long interval to 93.65 mg. per 100 ml. after the 3½ hour shorter interval seems to indicate that we are able to induce a measurable alteration in the metabolic status during the nocturnal fasting period.

Therefore, a reform of the customary hospital routine of a crowded meal schedule during daytime with an unduly long night interval appears to be in order by introducing a supplementary bedtime meal, at least in the type of subacute and chronic diseases where optimal nutritional results are of the essence.*

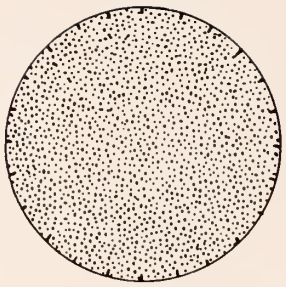
Conclusions

The meal schedule of 40 children suffering from pulmonary tuberculosis of various degrees of activity (exclusive of miliary and meningeal tuberculosis) was studied with regard to gain of weight and fasting blood glucose levels.

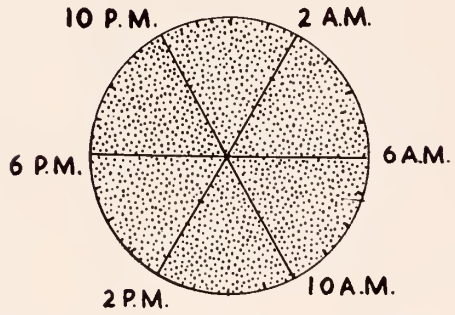
A 15 hour night interval between supper and breakfast led to a reduced gain of weight and a

* Whether this shortening of the fasting interval at night by way of an additional bedtime lunch may not prove beneficial in an entirely different group, like maternity cases, remains to be seen. It seems quite likely that the ability to nurse may receive a material boost through a reformed mealtime schedule.

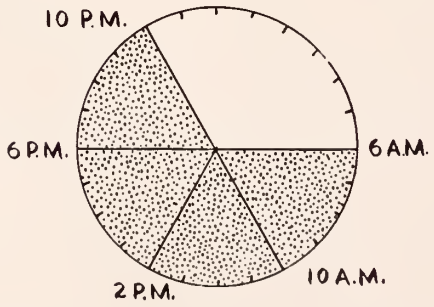
TABLE 4.—*Schemes of Mealtime Dials*



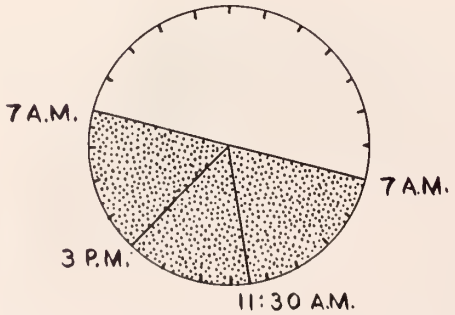
1. CONTINUOUS PRENATAL NUTRITION



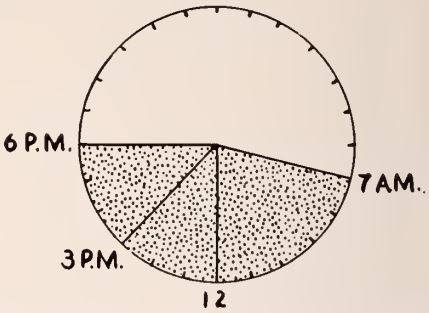
2. INTERRUPTED POSTNATAL AROUND THE CLOCK NUTRITION



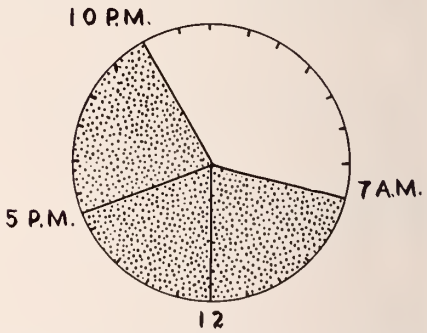
3. 8 HRS. NIGHT INTERVAL IN EARLY INFANCY



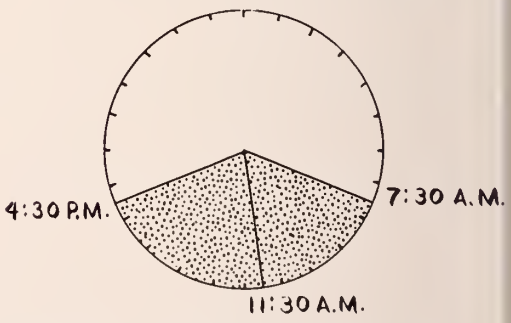
4. 11-12 HRS. NIGHT INTERVAL IN LATER INFANCY



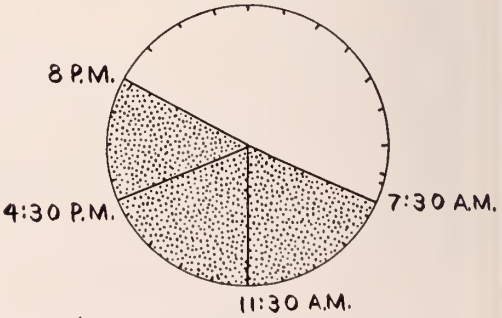
5. 12-13 HRS. INTERVAL AT TODDLER AND EARLY SCHOOL AGE



6. 9 HRS. INTERVAL OF AVERAGE JUVENILE ADOLESCENT & ADULT



7. 15 HRS. INTERVAL UNDER PREVAILING HOSPITAL SCHEDULE



8. 11½ HRS. INTERVAL UNDER AMENDED HOSPITAL SCHEDULE

reduced fasting blood glucose level at breakfast time.

An 11 to 12 hour night interval caused an increased average gain of weight and a higher average fasting blood glucose level.

The introduction of a supplementary bedtime lunch in all hospital cases, where optimal nutritional results are of the essence, appears advisable.

945 North Twelfth Street

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SCHEDULE OF PROGRAMS OF THE "MARCH OF MEDICINE"

On April 1, 1952, the March of Medicine began its seventh consecutive year of radio broadcasting. The programs, which are tape recorded, feature Dr. R. C. Parkin discussing various health problems with a lay person who is called "Your Medical Reporter." At present 33 stations in Wisconsin, one in Michigan, and one in Minnesota are cooperating in presenting this program as a public service feature. The most recent schedule is as follows:

Station	*City*	*Time*	
WHBY	Appleton	Saturday	8:30 a.m.
*WHKW	Chilton	Saturday	10:30 a.m.
*WHWC	Colfax	Saturday	10:30 a.m.
*WHAD	Delafield	Saturday	10:30 a.m.
WEAU	Eau Claire	Saturday	1:30 p.m.
KFIZ	Fond du Lac	Saturday	8:30 a.m.
WBAY	Green Bay	Saturday	5:45 p.m.
*WHLA	Holmen	Saturday	10:30 a.m.
WJMS	Ironwood, Michigan	Saturday	8:15 a.m.
WCLO	Janesville	Saturday	6:30 p.m.
WLIP	Kenosha	Saturday	11:15 a.m.
WKBH	La Crosse	Saturday	11:00 a.m.
WLDY	Ladysmith	Saturday	11:00 a.m.
*WHA	Madison	Saturday	10:30 a.m.
WIBA	Madison	Saturday	9:00 a.m.
WOMT	Manitowoc	Saturday	8:30 a.m.
WMAM	Marinette	Saturday	11:15 a.m.
WDLB	Marshfield	Saturday	10:45 a.m.
WIGM	Medford	Saturday	11:30 a.m.
WEMP	Milwaukee	Sunday	1:00 p.m.
WEKZ	Monroe	Friday	2:00 p.m.
WNAM	Neenah	Wednesday	8:30 a.m.
WOSH	Oshkosh	Saturday	11:00 a.m.
WIBU	Poynette	Thursday	2:30 p.m.
KAAA	Red Wing, Minnesota	Monday	9:15 a.m.
WOBT	Rhinelander	Saturday	9:15 a.m.
*WHRM	Rib Mountain	Saturday	10:30 a.m.
WJMC	Rice Lake	Saturday	10:00 a.m.
WRCO	Richland Center	Wednesday	10:00 a.m.
WHBL	Sheboygan	Sunday	1:00 p.m.
*WLBL	Stevens Point	Saturday	10:30 a.m.
WDOR	Sturgeon Bay	Thursday	9:15 a.m.
WDSM	Superior	Sunday	10:00 a.m.
WSAU	Wausau	Monday	4:15 p.m.

* These stations also carry programs at 7:00 p.m. on Wednesdays on FM only.

Detach this page and retain with insert in your files.

PHYSICIAN'S REPORT on BLINDNESS or PROGRESSIVE SIGHT LOSS

Purpose of The Report — To secure the services of state agencies as early as possible, to facilitate rehabilitation, and to avoid development of emotional disturbance through neglect and detachment. MAIL TO: Division of Public Assistance Services to the Blind, 2385 North Lake Drive, Milwaukee, Wis.

Name _____ Street _____

Birth Date _____ Sex _____ City _____

If Child, Give Name of Parent _____

Record of Sight: Right Eye _____ Left Eye _____ (GIVE ACUITY MEASUREMENT AND FIELD LIMITATION)

Prognosis: Good _____ Poor _____ Hopeless _____

What special service is suggested or needed? _____

Important The Person Covered by This Report is Aware of This Referral, and Will Welcome Cooperation of State Agencies ____. BE SURE THIS IS CHECKED.

Signed _____, M. D.

FOLD AND TEAR HERE

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Signed _____, M. D.

Detach and file. If more forms needed contact Committee on Visual Defects, % State Medical Society.

Hodgkin's Disease of the Stomach*

By ARNOLD S. JACKSON, M. D. and EDWARD B. SCHNELL, M. D.
Madison

HODGKIN'S disease usually is considered a medical rather than a surgical condition because of the widespread distribution of the lesions. However, it can occur in an isolated form and numerous instances have been reported where the disease was limited to single organs. In this paper we wish to discuss Hodgkin's disease when localized in the stomach. Two new cases are presented.

History

In 1832 Thomas Hodgkin first described lesions in the stomach and duodenum as a part of a generalized Hodgkin's disease. It was not until 1913 that the first case of gastric lymphogranulomatosis was described by Schlagenhaufer. The disease was apparently limited to the stomach without involvement of the regional lymph nodes. Prior to this such cases were probably diagnosed as sarcoma or tuberculous granuloma.

Incidence

As is true with any disease, the incidence varies with the author reporting the cases. In regard to generalized Hodgkin's disease, Wallhauser reviewed 15,783 autopsies and found 38 cases of Hodgkin's, an incidence of 0.24 per cent. Jackson and Parker point out that gastrointestinal symptoms are frequent in generalized Hodgkin's granuloma, but demonstrable lesions of the alimentary canal, either during life or at autopsy, are comparatively rare. In their review of 213 patients, 24 had gastrointestinal symptoms at onset, yet only 9 of these could subsequently be shown to have an intrinsic lesion of the stomach or bowel. The stomach was involved in 3 patients.

After studying 212 instances of proved Hodgkin's disease, Goldman and Victor concluded that the disease seldom attacks the gastrointestinal tract. The alimentary canal was involved in only 2 patients, the stomach in one and the sigmoid in another. This is in contrast to lymphosarcoma, in which the gastrointestinal tract is not an uncommon site of the disease. From 252 resected tumors of the stomach at the Lahey Clinic, reported by Marshall in 1911, 13 were classified as lymphomas, 8 of which were Hodgkin's disease. Goldman, in discussing generalized Hodgkin's, stated that it shows a preponderance in men between the ages of 20 and 40 years. In contrast to this, Sherman reviewed 75 cases of gastrointestinal Hodgkin's, of which over 50 per cent occurred in patients between the ages of 40 and 60. The largest group of patients were between 50 and 60 years. Men formed the majority of the patients in a ratio of almost two to one.

*From the Department of Surgery, Jackson Clinic, Madison.

Report of Cases

CASE 1.—R.M., a 58 year old Irish farmer, first came to the clinic on July 19, 1951, because he thought he had a left inguinal hernia. He also complained of belching, abdominal distress, and a 45 pound weight loss during the past three years.

The patient enjoyed good health until 1948, when he noticed epigastric distress following meals, associated with belching and occasional vomiting (never hematemesis). These vomiting episodes usually occurred after breakfast and relieved the distress. Since these symptoms always followed a meal, the patient decreased his food intake and became almost symptom free.

In June 1951, one month before his first clinic visit, an intermittent aching pain developed in his left inguinal region, which he believed was caused by a hernia.

He never had true pain or loss of appetite, no food intolerance, melena, or change of bowel habits.

In spite of his good appetite, his weight steadily decreased from 175 pounds in 1948 to 130 pounds just prior to surgery, a loss of 45 pounds in three years.

Physical examination showed a fairly well nourished white male, with evidence of weight loss. Abdominal and rectal examinations were negative. The external inguinal ring on the left was enlarged, but no hernia protruded. The lymph nodes in the cervical, axillary, and inguinal regions were not enlarged. The blood pressure was 117/70, pulse 72, temperature normal.

His hemoglobin was 80 per cent, red blood count 4,000,000, and white blood cell and differential counts were normal. The urine was normal except for a few pus cells and a trace of albumin. Sedimentation rate was 6 mm. per hour. The Kahn test was normal. The gallbladder contained several stones, and its function was slightly impaired. X-ray examination following a barium meal showed an irregular filling defect of the cardia on the lesser curvature of the stomach. (See figure 1.)

With a diagnosis of carcinoma of the cardia of the stomach, the patient was operated on September 4. An extensive tumor of the greater portion of the stomach was found. The lymph nodes in the greater omentum and periaortic region were enlarged. The liver was not involved. A high, subtotal gastrectomy was performed with an anterior gastrojejunostomy of the Hoffmeister type. The patient was discharged on the thirteenth postoperative day after an uneventful recovery. He received follow-up deep x-ray therapy.

The pathologic diagnosis was Hodgkin's disease of the stomach and accompanying lymph nodes.

Fig. 1.—(Case 1.) Note the irregularity and narrowing of the upper third of the stomach. This area did not fill on fluoroscopy.

Fig. 2.—(Case 2). Note the large ulcer crater on the lesser curvature of the stomach.

Gross description: The serosa of the stomach was bluish gray, dull and opaque, and finely granular over the anterior surface. Except for the pylorus, the wall was diffusely thickened and firmer than normal. The mucosa was reddish–brown, finely granular, and the rugal folds were firm and noncompressible. The wall of the stomach was 1.8 cm. thick. The mucosa lacked the usual movability due to a fixed submucosa. The fat of the lesser curvature contained a number of small, firm, pale gray lymph nodes.

Microscopic examination of the stomach lesion was not characteristic of Hodgkin's disease, but the lymph nodes gave a more clear-cut picture. They showed partial to complete loss of the normal architectural pattern. Only a few well-circumscribed foci of lymphocytes remained. The large Sternberg-Reed cells were numerous. Plasmocytes and eosinophils were widely distributed throughout the nodes.

After discharge the patient continued to gain weight and strength and on October 25 reported he was doing most of his duties and had no complaints.

Case 2.—R.C., a 53 year old merchant, entered the clinic on Sept. 16, 1950, complaining of dull, aching, epigastric pain of four months' duration. This pain was not related to food intake and was never accompanied by nausea or vomiting. It had been associated with "indigestion," mild anorexia, and a weight loss of 10 pounds. The patient gave a history of chronic constipation but never any melena.

The past history included an operation for intestinal obstruction at 15 years of age, repair of a bilateral inguinal hernia, and a bowel resection at age 20. He said he had rheumatic fever many years ago, and he was told he had a heart murmur.

Physical examination revealed a well nourished, well developed, white male in no acute distress. The heart was enlarged to the left anterior axillary line. A grade three diastolic murmur was present at the base, and a harsh systolic murmur was present over the entire precordium. The lungs were clear to auscultation and percussion. Except for several scars, the abdominal examination was negative. No enlargement of lymph nodes was detected. The blood pressure was 128/62 and the pulse 84, temperature normal.

On Oct. 3, 1950 the hemoglobin was 80 per cent, red blood cell count 4,160,000, and white blood cell count 9,000. The Kahn test, icterus index, and urine were normal. An x-ray examination after barium meal revealed a large ulcer on both the lesser and greater curvature of the stomach (see figure 2).

On Oct. 17, 1950 he was admitted to the hospital because of a low blood count. He then gave a history of gastrointestinal bleeding with both hematemesis and melena. His hemoglobin was 55 per cent and red blood cell count 2,490,000. His fasting gastric contents had 22 units of free acid. After repeated bouts of bleeding and transfusions he was prepared for laparotomy which was done on Nov. 22, 1950.

A mass about 3 by 1 inches was found on the greater curvature of the stomach, and on the lesser curvature was a smaller mass which appeared to be inflammatory. The stomach was opened and an ulcer was found in each of the masses. Small, firm lymph nodes were present in both the lesser and greater omentum. A partial gastric resection was done with a gastrojejunostomy of the Hoffmeister technic. The patient made an uneventful recovery and received follow-up deep x-ray therapy.

The pathologic diagnosis was malignant lymphoma of the stomach. From the histologic appearance of the lymph nodes it was classified as Hodgkin's disease. Grossly the lesion of the greater curvature was circular and measured 6 by 6 cm. The lesion had scalloped, raised, firm margins with a flat granular base. On section, the wall was seen to be thickened up to 1.4 cm.; this thickness was caused principally by an increase of pale yellowish–gray tissue in the mucosa and submucosa. The lymph nodes in the lesser curvature were pale gray, and measured up to 0.8 cm. in diameter.

Symptomatology

The symptomatology in this condition is more like that of carcinoma of the stomach than that of generalized Hodgkin's disease. Singer pointed out that, as a rule, the characteristic systemic manifestations are lacking in the localized stage. Paroxysms of fever (Pel–Ebstein), which are highly suggestive of Hodgkin's disease, are generally absent until the disease becomes more or less disseminated.

In this condition, as in carcinoma of the stomach (Supino), the gastric symptomatology depends on the location of the tumor and on the general condition of the patient.

According to Hayden and Apfelbach, the most common clinical findings in gastrointestinal Hodgkin's disease are diarrhea, abdominal pain, rapid cachexia, secondary anemia, leukopenia or normal leukocyte count, and fever. Sherman stated that with the gastric type of lesion, the chief symptoms are epigastric pain and distress of varying severity after meals, nausea, vomiting, eructations of gas, weakness, and loss of appetite and weight. There may also be hematemesis and melena. The duration of symptoms may vary from a short time to several years with remissions and exacerbations.

Physical examination will frequently reveal no abnormality. There may be a palpable mass as in carcinoma of the stomach and/or emaciation. Fever, enlargement of lymph nodes, liver, and spleen are rare.

Almost any complication occurring in gastric ulcer or carcinoma may occur in Hodgkin's disease. Perforation and hemorrhage are perhaps the most frequent. The hemorrhage may be severe and even fatal.

Because the clinical picture is not specific the preoperative diagnosis can be no more than a guess. There is rarely a clue that will even suggest the correct pathologic diagnosis.

Laboratory Findings

The blood picture in the localized type is not characteristic. It may be normal, or severe anemia may be present. In 1931 Singer observed that eosinophilia and monocytosis are, like fever, usually absent in patients with isolated lesions. Koenig in 1941 said that the most common variation in the differential blood count was a decrease in the lymphocytes and a slight eosinophilia.

Other laboratory findings such as achlorhydria, occult blood in the stool, and sedimentation rate were of no aid in determining the type of lesion.

In reviewing 152 cases from the literature, Taylor found that with gastroscopic examination no characteristic diagnostic feature could be recognized.

Roentgenologic Findings

There are no roentgen findings characteristic of this condition from which a diagnosis can be made with certainty.

However, Feldman believes that the roentgenologic examination, when correlated with the clinical data, may suggest the possibility of a gastric sarcoma. He emphasized that the following signs may be observed in lymphosarcoma, notably: (1) a filling defect with smooth margins; (2) a localized tumor which is round and smooth; (3) in the diffuse type, involvement of large portions of the stomach, simulating linitis plastica; (4) mucosal rugae in thick folds as shown on relief pictures of the stomach; (5) the presence of palpable tumors in young individuals strongly suggesting the possibility of sarcoma; and (6) the presence of multiple ulcers suggesting sarcoma. Sherman also added that in some cases the peristalsis was not interfered with to the extent generally seen in carcinoma.

Differential Diagnosis

Numerous authors, as mentioned by Marshall, give clinical or roentgenologic findings which should suggest the possibility of such a lesion. In spite of this, it is a rarity for the diagnosis to be suggested preoperatively or even at the time of the operation. Clinically the lesion is most frequently confused with a carcinoma or occasionally treated as a benign gastric ulcer. Marshall believes that in differentiating Hodgkin's disease from carcinoma one feature that may be significant is that, in general, patients with Hodgkin's are in good physical condition, and do not show cachexia or anemia to the degree seen in patients with carcinoma. Lehman and Hawkes also emphasized that early pain is more frequent in Hodgkin's disease of the stomach than in carcinoma. The final diagnosis is made with the microscope, but is not always easy, especially in the early stages.

Pathology

Hodgkin's disease is generally classified with sarcoma. Marshall describes two types of gastric sarcoma, those arising from smooth muscle and those arising from lymphoid tissue. The lymphoid

LIBRARY OF THE

tumors may be divided into the following groups: (1) Hodgkin's disease, (2) reticulum cell sarcoma, (3) lymphosarcoma, and (4) malignant lymphoma. The etiology of the disease is still obscure. According to Sherman, most investigators classify it as a granuloma of unknown etiology.

Supino describes three phases: (1) granulomatous infiltration (nodular, neoplastic or diffuse); (2) necrosis with ulcer formation; and (3) sclerosis (cicatrization). The disease may consist of a single tumor of the gastrointestinal tract, or it may be extensive and associated with multiple ulcers.

Singer suggested that the tumor of Hodgkin's disease is soft, flat, and infiltrating. It is usually limited to the distal portion of the stomach, associated with an unusual number of large, succulent, isolated lymph nodes. Marshall stressed that lymphoid tumors show no predilection for either wall or curvature. He mentioned that in some cases the tumor infiltrated under intact mucosa, and smoothed it out or pushed it up into giant rugal folds.

As was true in our cases, the histologic picture in the gastrointestinal tract is by no means as simple and definite as it usually is in the lymph nodes. The histologic picture as described briefly by Luxardo is characterized by proliferation of lymphohistiocytes, lymphocytes, polynuclear cells, eosinophilic cells, and by the characteristic Sternberg-Reed cells.

Treatment

Surgical extirpation is the treatment of choice for localized Hodgkin's disease of the stomach. Since these are generally diagnosed as carcinoma, the patients will usually come to operation and be treated as such. Even if the diagnosis is suspected, the patient should be treated surgically as in carcinoma of the stomach. If the lesion is inoperable, a biopsy should be taken without fail. The corrected diagnosis can then be made and the patient given the benefit of roentgen therapy in case he has Hodgkin's disease instead of carcinoma.

Postoperative irradiation should be employed in all lymphoid tumors. Marshall says this increases the five year survival rate. He cited one patient in whom Hodgkin's disease of the stomach was too extensive to be resected. After operation the patient was given roentgen therapy over the abdomen and was alive over five and one-half years later. The palliative value of deep x-ray therapy is shown in Daubresse's patient, a 35 year old white female who was treated by deep roentgen therapy for multiple localizations of Hodgkin's disease. Two years before her death a barium meal and x-ray examination revealed a large gastric tumor, which disappeared rapidly under roentgen therapy. A subsequent stomach examination was normal. The gastric tumor recurred in six months and again disappeared after roentgen therapy.

Very little has been written about the treatment of localized Hodgkin's disease with nitrogen mustard. Jacobson reports encouraging results in the generalized form. Fever and malaise are frequently relieved; lymph node enlargement, splenomegaly, and hepatomegaly usually regress rapidly. Repeated courses of treatment with the drug have produced further remissions. Certain cases of Hodgkin's disease are classified as roentgen ray resistant, and significant clinical remissions have been produced with the nitrogen mustards. This is well to keep in mind since in the majority of patients Hodgkin's disease of the stomach does not remain localized indefinitely.

Prognosis

Singer pointed out that even when a careful exploration fails to demonstrate evidence of granulomatous tissue other than that extirpated, a guarded prognosis should be made. Gross lesions in inaccessible regions and microscopic involvement of the structures examined at the operating table may escape detection. In a study by Lehman and Hawkes, the average duration of life after onset of symptoms in generalized Hodgkin's disease was 32.06 months. In Hodgkin's disease of the stomach, Marshall found the prognosis much better than it is with carcinoma. He mentioned 5 patients with localized Hodgkin's disease who lived more than five years.

Summary

Two patients with Hodgkin's disease of the stomach are reported.

The important features of this condition are the following:

1. If a gastric lesion is associated with the typical picture of Hodgkin's disease, the condition is probably not localized.

2. Since Hodgkin's disease of the stomach cannot usually be differentiated clinically from carcinoma, it is important to regard it as a surgical lesion.

3. Localized gastrointestinal Hodgkin's disease occurs at a later age than does the generalized form.

4. Biopsy of a non-resectable lesion should be taken since it may prove to be sensitive to roentgen therapy.

5. The perigastric lymph nodes are often better for microscopic diagnosis than the gastric lesion itself.

6. Surgical treatment, roentgen therapy, and the use of nitrogen mustard will probably prolong the life of these patients.

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16 South Henry

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BUREAU FOR HANDICAPPED CHILDREN SCHEDULES ORTHOPEDIC FIELD CLINICS

Orthopedic field clinics for the last half of 1952 have been scheduled by the Bureau for Handicapped Children, State Department of Public Instruction. The clinics are conducted for persons under 21 years of age who come within the state's definition of a crippled child. It is preferred that referrals be made by the family physician, but when this is not feasible, arrangements may be made by writing to the Bureau. Unless otherwise directed, forms for the purpose of referral may be obtained from the Bureau for Handicapped Children, and should be requested in advance of the clinic date. It is important that the Bureau know well in advance the number of persons to be examined so that plans may be made for the required personnel.

Families who return the signed referral form will be notified of the hour of their appointment a few days before the clinic. Parents and physicians are invited to attend the clinic with the child; and, if the public health nurse believes that the child referred to the clinic for orthopedic reasons is also in need of other services, the Bureau asks that it be notified of this fact.

Lancaster	July 9
Darlington	July 10
Eau Claire	July 24 and 25
Ashland	August 6 and 7
Wausau	August 20 and 21
Manitowoc	September 4 and 5
Marinette	September 10
Kenosha	September 16 and 17
Superior	September 19
Green Bay	September 25 and 26
Racine	October 9 and 10
La Crosse	October 15, 16 and 17
Sheboygan	October 23 and 24
Chippewa Falls	October 30 and 31
Eau Claire	November 13 and 14
Appleton	November 20 and 21
Fond du Lac	December 4 and 5

Inquiries concerning these clinics may be addressed to the Bureau for Handicapped Children, Room 146 North, State Capitol, Madison 2, Wisconsin.

Signs and Symptoms of Certain Anxiety Reactions*

By OVID O. MEYER, M. D.
Madison

Introduction

IT IS a widely acknowledged fact that medical problems requiring that the attention of the physician be directed to both the psychic and somatic aspects are manifold. Frequently the psychic factors are the more important and are accountable for the somatic complaints. Although there are too few psychiatrists to care for these patients, the majority actually do not require the attention of the specialist. The general practitioner, internist, and pediatrist can adequately care for most of them, and every specialist should be cognizant of and alert to the somatic symptoms and signs of anxiety reactions in order to avoid many unfortunate mistakes and needless operations. Furthermore, the doctor with a modicum of experience can usually differentiate between the mild and the severe cases; the former he can often treat successfully himself; the latter, a minority, should be referred to a psychiatrist.

A number of doctors are prone to be oblivious to many of the symptoms and signs of functional disease and to seek the organic disease alone, feeling insecure in their appraisal of non-organic disease. This insecurity, I think, is due to a certain vagueness in much that is said and written about these psychosomatic problems. This communication aims to be as explicit as possible and to convey that there are many specific signs indicating that the particular medical problem is primarily functional rather than organic. What is suggested here is largely based upon experience as an internist without any special training in nervous disease, but with a deep interest in these unhappy people.

It must be appreciated that for every patient three possible categories must be considered under which the case may fit.

(a) In nearly every patient with organic disease, there is some functional overlay of varying intensity. The sick patient, whether his illness be acute, subacute, or chronic, has mental and personality changes of such a nature that he is not himself while he is ill and usually not for some time after the illness. This is widely recognized and accepted by nearly all physicians.

(b) A second category includes those cases in which functional disease is primary, possibly due to a maladaption to the environment in any of many ways, with associated or perhaps resultant organic disease such as peptic ulcer, ulcerative colitis, dermatitis, arthritis (palindromic), or hypertension.

(c) A third is comprised of patients with functional disease which exists without evident organic disease; or, if organic disease exists, it is not responsible for the symptoms. Often in the patients of this group there is a physiologic disturbance such as hypertonicity of the colon, tachycardia, or excessive perspiration.

Many of the symptoms that should make the doctor alert to this true situation are so common and well recognized that the diagnosis is obvious. Other less common symptoms may be equally as important and suggestive of the proper diagnosis of an anxiety tension state.

Symptoms

In this discussion, no attempt will be made to give the differential diagnosis to be considered for each symptom. The purpose is rather to list the symptoms and signs that should make one consider the possibility or probability of non-organic disease.

(a) *Headache.*—This is a very common symptom, most often localized in the back of the head and neck, although it may be frontal. If the pain is on the top of the head, it usually suggests a severe, often hysterical type of psychoneurotic disorder.

(b) *Inability to read or think.*—These symptoms indicate the patients' inability to concentrate on anything but themselves and their problems.

(b_1) *Insomnia.*—A symptom that is often on the same basis as (b). Some have trouble getting to sleep; others develop the pattern of awakening early without the ability to fall sleep again—a very suggestive symptom of an emotional disorder.

(c) *Dizziness.*—This is frequently a symptom resulting from hyperventilation inadvertently carried on, which may be a conditioned reaction to stress.

(d) *Palpitation and tachycardia.*—These are common signs of anxiety frequently associated with (c), (e), and (f)—as resultants of hyperventilation.

(e) *Faintness.*—This is also common with hyperventilation of tension states and an important cause of fear.

(f) *Sense of tightness in the chest.*—A symptom that is usually due to hyperventilation and awesome for the patient but less common than the other symptoms listed.

(g) *Anorexia.*—This is a very common symptom which frequently occurs for brief periods, with the recurrent episodes of anxiety and excessive emotional tension experienced by many individuals. However, chronic anorexia with resultant weight loss or failure to gain weight is often due to fa-

*From the Department of Medicine, University of Wisconsin Medical School.

Read in part at a Symposium on Psychosomatic Medicine, Veterans Hospital, Tomah, Wis., September 8, 1951.

tigue which develops because of persistent emotional stress and overactivity and consequent wasted purposeful or purposeless muscle activity.

(h), (i), (j)—*Nausea, Emesis, Diarrhea*—These occur with further aggravation commonly reflecting sustained repressed resentment. Little or no anxiety may be associated.

(k) *Aerophagia.*—Swallowing of air and then belching occurs perhaps more frequently in the somewhat debilitated tense person and is likely to be habitual. It is relatively common after an operation or after a prolonged or serious illness, especially in a tense, high-strung person.

(l) *Abdominal pain.*—The pain of the spastic colon, which is generally present in anxiety-tension states, usually occurs throughout the abdomen or is variable in location, more often on the left, and is *relieved by defecation.*

(m) *Backache.*—In my experience, this is not a very common symptom. However, coccydynia is nearly always a symptom of psychoneurosis, and, as a consequence, surgical measures such as amputation of the coccyx are usually very disappointing in their results.

It is, of course, obvious that several of the symptoms listed here may exist in the same individual. However, one symptom is likely to predominate, although a shift to another predominating symptom later is not unusual. Characteristically, even if there is a multiplicity of complaints, a certain vagueness is common in the patient's description of his symptoms.

The type of person who comes to the doctor with a list of complaints on a piece of paper is very familiar to all physicians. The diagnosis of psychoneurosis can usually be made readily. What is more, the psychoneurosis is usually of long standing, and the patient is insecure—"I might forget something."

Any of these symptoms or symptom complexes should put the physician on guard. Sometimes the first impression gained from the history of organic disease may be altered when a careful social history is taken and it is found that the husband is an alcoholic and a ruffian, the supervisor of the job is difficult, or there exists an unhappy love affair or some other situation of stress in his everyday life. Obviously, circumstances such as these may readily account for many psychic and somatic complaints. The social history is extremely important, and it is very distressing to see how often it is haphazardly and inadequately recorded. To obtain it properly, the inquirer must be passive and objective, neither facetious nor scolding, neither critical nor too aggressively sleuthing. Slowly, if the approach is proper, the story will come out, and the diagnosis will be made possible.

The past medical history pattern may also be significant. Unnecessarily prolonged illnesses, multiple operations, or obscure and mild illnesses are often suggestive.

In addition, the family history may be vital in establishing the diagnosis. The patient may think that he has heart disease or cancer, and may present a good symptomatic pattern because of knowledge of the complaints of some relative ill or recently deceased because of one of these conditions.

After the history, a complete and careful physical examination should be done to reassure the patient as to one's thoroughness and to have a firm foundation upon which to build the psychotherapy that is to follow. The examination can do harm and make the patient needlessly apprehensive, however, if it is overdone in certain details. For example, if too much attention is directed to the heart, or if the blood pressure is checked at the time of each visit, anxiety on the part of the patient may result. The complete examination should be done with finality, and, unless new indications arise, it should not be checked in all details for many months. One must realize, of course, that sooner or later the neurotic does develop serious organic disease of some type or other, even as do all of us, and the physician may be sadly awakened if he forgets this fact.

Signs

The specific physical signs that immediately suggest an anxiety tension state may be listed as follows:

(a) *Sighing.*—The patient who, while sitting at your desk giving the history, sighs frequently, is nearly always fatigued and is fatigued because of a state of emotional unrest and tension of some duration. That patient is hyperventilating and, hence, is also likely to have the symptoms of hyperventilation—i.e., dizziness, lightheadedness, apprehension, palpitation, a sense of tightness in the chest, and possibly precordial pain.

(b) *Tinted glasses.*—Whenever a patient wears tinted glasses, one can suspect an anxiety tension state and/or constitutional inadequacy. This is not invariably so, not everyone who wears tinted glasses has psychoneurosis, but it is very very commonly true that tinted glasses have this significance and I have confirmed this observation hundreds of times. Our residents are usually skeptical when first introduced to this sign, but are readily converted after one or two months of looking for its significance and observing the type of individuals who demonstrate it. The tinted glasses have two purposes: First, they serve as a shield from the world; and, secondly, because these patients are uneasy and secrete an excess of adrenalin, their pupils are often widely dilated, so that bright light is distressing.

(c) *Bitten fingernails.*—Bitten fingernails almost invariably indicate that the person is a nervous, emotionally unstable person. I have seen several hundred patients with hyperthyroidism, and they are nervous people, too, but I can remember no more than three of these who bit the fingernails.

(d) *Axillary perspiration.*—In the tense person, excessive axillary perspiration will often be present and will drip to the examining table. If the patient is recumbent for some minutes, two round spots of perspiration will be present on the sheet after he gets up from the table. I have observed this sign more often in men, and it is a specific sign of tension, which may exist only because of being in the doctor's office and may not be primarily indicative of a psychoneurosis, although neurotics commonly exhibit the sign.

Jitteriness and restlessness of the patient, as observed when one talks to and examines the patient, need not in themselves indicate that a significant emotional disorder exists. It often does, but there is the go-getter type who is often jittery but in no sense neurotic.

With these hints from the history of the illness and the physical examination and from a carefully obtained social, past medical, and family history, one can usually arrive promptly at the correct diagnosis. It is wrong, very wrong, to make a diagnosis of functional disease only by exclusion of organic disease, for organic disease may exist—gallstones, for example—without its being the cause for the symptomatology. The approach must be a positive one, and it can be if some of these symptoms and signs are kept in mind.

And then, having made the diagnosis, one should offer the patient a careful explanation of his complaints, step by step. The physician must not be too precipitous, for harm could result. The patient will usually require repeated conferences and reassuring supervision. Temporarily, mild sedation may be helpful, but this therapy should, ordinarily, be of short duration. The physician, contrary to frequent practice, should neither ignore the patient, promptly refer him to someone else, nor treat him for long periods with sedatives merely because he feels unsure of himself in the management of these cases.

Understanding discussions between physician and patient are of great benefit, and are very worth while. I have seen ambulance-transported patients enter the hospital and, after two or three weeks of care composed largely of interviews, be well and able to walk out of the hospital. It is true that relapses often occur, but during remissions the patient may be a functionally 100 per cent individual, whereas the cardiac patient, for example, who has regained compensation may be but 50 per cent of normal functionally. Time spent with the patient who has psychosomatic disease is generally time well spent and extremely worth while. These individuals are usually very interesting and very grateful patients. And, as Dale Groom[1] has said, "A patient's mind can be as interesting as his colon." Finally, we must remember that we all have a threshold for indefinite anxieties, pains, and bodily complaints. It is just that some have higher thresholds than others.

University Hospitals.

REFERENCE

1. Groom, D.: Some applications of psychiatry in general medicine, J.A.M.A. 135:403-408 (Oct. 18) 1947.

1952 ESSAY CONTEST ANNOUNCED BY AMERICAN SOCIETY OF PLASTIC AND RECONSTRUCTIVE SURGERY

The Foundation of the American Society of Plastic and Reconstructive Surgery offers awards in junior and senior classifications for original contributions in this field.

Junior Classification: Two six month scholarships in leading plastic surgery services in the United States, England, and Italy will be awarded.

Senior Classification: The Foundation's annual prize, a silver plaque, will be given for the best essay presented at the annual meeting of the Foundation.

The contest is restricted to residents and surgeons in the practice of plastic and reparative surgery for not longer than five years. The subject matter of the essay should be the result of some original clinical or laboratory research in plastic surgery of recent date. All essays should be submitted in quadruplet form in English with no indication of the writer's name or his institutional affiliation, but should be identified by a legend. This legend should appear on the outside of a sealed envelope which contains the name, address, and affiliations of the contestant.

All entries must be received by the award committee not later than September 1, 1952. Further inquiries should be addressed to: The Award Committee, % Jacques W. Maliniac, M. D., 11 East 68th Street, New York 21, New York.

Proceedings of the Milwaukee Academy of Medicine, December 18, 1951

Atherosclerosis, Lipoproteins, and Coronary Artery Disease*

By John W. Gofman, M. D., Ph. D.; Hardin B. Jones, Ph. D.; Thomas P. Lyon, M. D.; Frank Lindgren; Dean Graham; Beverly Strisower, and Alex Nichols

A WEALTH of information, both clinical and experimental, accumulated over the years, has provided undeniable evidence that atherosclerosis and its serious clinical sequelae, e.g., coronary artery disease, are in someway related to serum lipids.

The major problems are:

A. Which serum lipids are actually related to atherosclerosis.

B. If certain serum lipids are associated with atherosclerosis, what is the nature of that association? Are the involved serum lipid constituents actually etiologic agents in the disease, or are they a reflection of a metabolic disturbance which produces both serum lipid alterations and atherosclerosis independently?

C. Will knowledge of the status of a patient with respect to abnormality of serum lipids provide diagnostic or prognostic information?

D. Will alteration of the serum lipids toward normal be of prophylactic and therapeutic value in atherosclerosis, especially in such sequelae as coronary artery disease?

Certain evidence has now developed concerning each of these problems. This evidence may be considered with respect to each problem raised above.

A. The determination of which serum lipids are related to atherosclerosis depends upon the ability to characterize the serum lipids in individual patients. By our application of ultracentrifugal methodology, it has been possible to describe serum lipid transport in an individual patient in terms of a series of giant lipoprotein components. Essentially all of the chemical lipid constituents of serum (cholesterol, free or esterified, phospholipids, fatty acids, and neutral fat) can be accounted for quantitatively in one or more of the ultracentrifugally measurable lipoproteins.

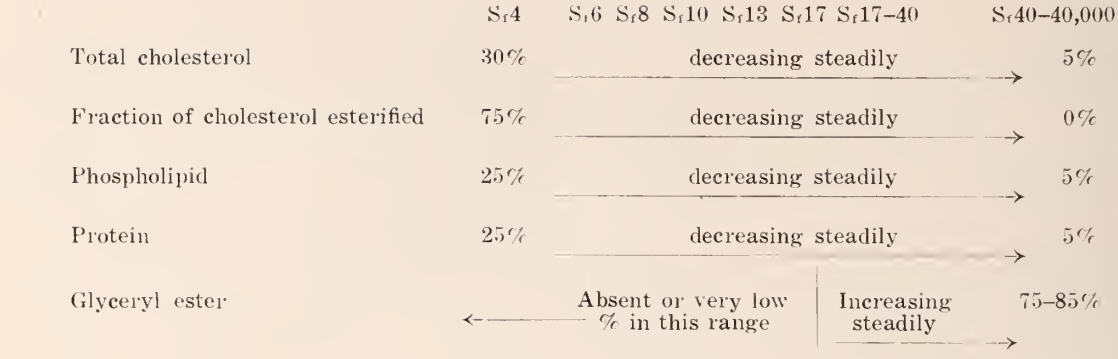
In the ultracentrifuge, the lipoproteins, being of relatively low density, can be made to undergo flotation, since it is possible to render the solutions carrying them more dense than the lipoproteins by the simple expedient of adding salt. This allows separation of the lipoproteins from the dense serum proteins, such as albumin and globulin. Then in an analytical flotation run photographs are obtained which enable us to determine what lipoprotein species are present, and at what concentration such lipoproteins exist in the serum of a particular human subject. Since several species of lipoproteins may be present, we have found it useful to describe these lipoproteins either by

(a) *Flotation rate* in the ultracentrifuge under specified conditions. The units used are so-called Svedberg units (in honor of the inventor and pioneer of the ultracentrifuge method). Thus a particular lipoprotein may be named or characterized by its flotation rate in S_f units (Svedbergs of flotation).

or (b) *Density of the lipoprotein* in grams per cubic centimeter. Since the various lipoproteins differ from one another in this property (in addition to other differences), it is often useful to describe or name a molecular species in terms of its density, e.g., a lipoprotein is spoken of as being in the 1.07 grams per cubic centimeter class. An arbitrary but useful split has been made in the case of human lipoproteins at a density of 1.063 grams per cubic centimeter. All these of higher density than this are referred to as "high-density lipoproteins," whereas those of lower density are designated as "the low-density lipoproteins." It is this latter class, the "low-density lipoproteins," which will be considered in the remainder of this discussion.

In the human the various types of low-density lipoproteins which may be present are now characterized and information is accumulating as to their chemical composition and biological interrelations. The human serum lipoproteins known to exist together with their chemical composition are the following:

* From the Donner Laboratory of Medical Physics; and the Radiation Laboratory, Department of Physics, University of California, Berkeley, California.



The crucial feature of distinction among humans of various ages and clinical categories is in the concentrations of the various classes of lipoproteins habitually present in the serum. Individual patients may be described by their "lipoprotein spectrum." The "normal pattern" and deviations therefrom are as follows:

"Normal" Pattern

(1) Lipoproteins of S_f4 and/or S_f6 present at low or moderate concentrations. *Minimal* levels of higher S_f components except for transient elevations in S_f30–40,000 following fatty meals.

"Minimal" Defect

(2) Lipoproteins of S_f4 and/or S_f6 at increased concentrations but without any increase in higher S_f components as compared with (1).

"Minor" Defect

(3) Lipoproteins of S_f4 and/or S_f6 *plus* S_f8 in increasing concentration.

Progressively "More Severe" Defect

(4) $S_f\ 4 + S_f6 + S_f8 + S_f10$.

(5) $S_f\ 4 + S_f6 + S_f8 + S_f10 + S_f13$.

(6) $S_f\ 4 + S_f6 + S_f8 + S_f10 + S_f13 + S_f17$.

(7) $S_f\ 4 + S_f6 + S_f8 + S_f10 + S_f13 + S_f17 + S_f17$–20.

(8) $S_f\ 4 + S_f6 + S_f8 + S_f10 + S_f13 + S_f17 + S_f17$–$20 + S_f20$–40.

(9) $S_f\ 4 + S_f6 + S_f8 + S_f10 + S_f13 + S_f17 + S_f17$–$20 + S_f20$–$40 + S_f40$–40,000.

(In this group the S_f40–40,000 can be of transient existence following meals or may be sustained even post-absorptively.)

(10) "Most Severe" Defect

As in (9) except that the S_f4 and S_f6 may be depressed to quite low concentrations. This may be regarded as a general shift toward higher S_f lipoproteins, and is comparable to that which appears in the rabbits in the later phases of cholesterol-Wesson oil feeding.

The physiology underlying the presence of such molecules in serum appears to be that these lipoproteins represent, in part at least, a sequence of molecules involved in the normal metabolism of fat and fatty acids, with progressive transformation of molecules of high S_f classes into those of lower S_f classes.

The pathologic physiology underlying the presence of elevated concentrations of certain of these lipoproteins appears to be either, (a) An abnormal rate of delivery of a particular lipoprotein to the serum, or (b) A partial metabolic block in the normal conversion of a particular lipoprotein to those of lower S_f classes. In either event the result may be a steady state elevation in serum level of that lipoprotein.

Our studies of patients with coronary artery disease (a major share of which is atherosclerotic in origin) have revealed beyond doubt certain critical facts:

(1) Two classes of lipoproteins are elevated significantly and independently in patients with coronary artery disease as compared with "normals" of the same age and sex (some of whom, of course, have *silent* atherosclerosis). These classes of lipoproteins are (a) The lipoproteins between S_f12 and S_f20 ("the S_f12–20 class"), and (b) The lipoproteins between S_f20 and S_f100 ("the S_f20–100 class").

The S_f 12–20 class of lipoproteins is not acutely influenced by food intake, whereas the S_f20–100 class (especially the S_f35–100 group) may be acutely elevated following ingestion of fat-containing meals.

(2) Each of the above lipoprotein classes contributes significantly and independently in the association with atherosclerosis.

(3) Together the S_f 12–20 + the S_f 20–100 classes of lipoproteins contribute *essentially all* of the relationship of serum lipids with atherosclerosis, yet they represent, on the average, only 10 to 15 per cent of the total lipids of serum, and, specifically only 10 to 15 per cent of the cholesterol of serum. The cholesterol and other lipids present in the remaining 85 to 90 per cent of serum lipoproteins provide no independent contribution to atherosclerosis.

(4) Since only a small fraction of the cholesterol-containing lipoproteins is of importance in atherosclerosis, the variations in the remaining bulk of serum cholesterol serve more to obscure and confuse the relationship of serum lipids to atheroscle-

rosis than to clarify it. As a result the serum cholesterol determination is definitely an unsatisfactory guide in evaluation of atherosclerotic potentialities. At any total serum cholesterol level, the S_f 12–20 and and S_f 20–100 classes of lipoproteins are higher in patients with coronary artery disease than in normals, over the range from *low* cholesterol levels through *high* cholesterol levels. Conversely, when patients with coronary disease are matched with normals at the same S_f 12–20 + S_f 20–100 levels, the serum cholesterol level *fails* to segregate the patients with coronary disease from the normals.

At *low* total serum cholesterol levels, those patients with high S_f 12–20 + S_f 20–100 lipoprotein levels may be anticipated to be developing atherosclerosis.

At *high* total serum cholesterol levels, those patients with low S_f 12–20 + S_f 20–100 lipoprotein levels may be anticipated to be relatively protected from atherosclerosis.

(5) In a classical *hypercholesteremic* group, patients with xanthoma tuberosum (known clinically to develop excessive atherosclerosis), the S_f 12–20 + S_f 20–100 lipoproteins average 2 to 2½ times higher than in equivalently hypercholesteremic individuals who are clinically normal.

B. While the association of the S_f 12–20 and S_f 20–100 lipoproteins with atherosclerosis is strong, there is no *direct* evidence that these molecules are etiologic in the sense that they produce atherosclerosis directly by deposition in some manner from serum. We consider the probability good that this is the case. In any event, until and unless evidence to the contrary arises, this hypothesis provides a fruitful basis for prophylactic and therapeutic studies in atherosclerosis.

C. Obviously the ability to predict which "normal" individuals are developing atherosclerosis excessively will be of clinical value. Our data already show statistically significant association of elevated S_f 12–20 levels with the development of coronary disease *de novo* in "normals." Studies in progress now will provide additional information on a much larger series this year.

Follow-up study of patients with established coronary artery disease shows statistically significant association of elevated S_f 12–20 lipoprotein levels with early recurrence of myocardial infarction. There is thus established prognostic import in the S_f 12–20 lipoprotein level. It is likely that we will be able to demonstrate similar prognostic significance for the S_f 20–100 lipoproteins.

D. Certain factors, exclusive of frank diseased states such as diabetes, xanthomatosis, nephrosis, myxedema, and hepatitis, are now known to influence the level of the atherosclerosis-associated S_f 12–20 and S_f 20–100 lipoprotein levels. They are as follows:

(1) *Obesity,* which is almost universally the result of excessive caloric intake. The association of obesity with elevation of the S_f 12–100 lipoproteins (S_f 12–20 + S_f 20–100) is highly significant, although of moderate degree. This association may be of sufficient degree to explain the moderate clinical correlation of obesity with excessive atherosclerotic vascular disease.

(2) *Dietary fat intake*—Acutely, the ingestion of a meal high in mixed fats produces elevations especially in the S_f 20–100 lipoprotein levels. Chronically, restriction of dietary fat produces a fall in the S_f 12–20 and S_f 20–100 lipoprotein levels in a large proportion of, but not in all, patients. In part this effect is due to the usual association of reduced calorie intake on a fat-restricted diet. In part it appears also due, in some patients, to the reduced fat intake, per se.

(3) *Heparin administration*—Heparin is the most powerful agent we have encountered in shifting the serum lipoprotein pattern toward normal in humans and experimental animals. The S_f 20–100 lipoprotein class is generally wiped out within 30 minutes after the administration of 25 to 100 mg. of heparin intravenously in humans. The S_f 12–20 class shows a transient elevation, followed by a decrease. Within 24 hours, however, the great majority of humans revert to their pre-heparin lipoprotein pattern.

Chronic lowering of lipoprotein levels in some humans is possible by intermittent heparin injection. Much work remains to be done in establishing possible dosage forms and schedules.

Efficacy of Lipoprotein Alterations

A significant decrease in recurrence rate of myocardial infarction has been established in patients with established coronary artery disease whose levels of S_f 12–20 lipoproteins have been significantly reduced by dietary fat restriction. Part of this protection may be associated with the alteration of lipoprotein level associated with the control of obesity.

Heparin administration has been shown by Graham, et al, in our laboratory to protect rabbits against cholesterol-induced atherosclerosis.

The future development of this approach follows two lines:

(1) Further evaluation of the prognostic and predictive implications of elevated S_f 12–20 and S_f 20–100 levels, together with evaluation of the clinical efficacy of reduction of such levels in the management of atherosclerosis.

(2) The understanding of the nature of the metabolic error which leads a sizeable fraction of the human population to have elevations of the atherosclerosis-associated lipoproteins.

The latter is of greater fundamental importance but may lag behind certain of the practical applications of the former.

Housing the Migrant Worker

As It Looks to the State Board of Health

HOUSING and environmental sanitation for migrant workers are recognized as factors in the control of communicable diseases in Wisconsin both among the migrants themselves and among the permanent residents of our communities.

Progress in the control of these diseases has been achieved in our permanent communities through well-established activities in the fields of environmental sanitation, milk pasteurization, livestock disease eradication, immunization programs and practices, and proper isolation and quarantine procedures coupled with early diagnosis and treatment. The migrant workers who have been coming to Wisconsin in increasing numbers since 1930 have not fitted into these activities because of the relatively short time the workers remain in an area and because the communities have not yet accepted their obligations to these people whose labor is indispensable.

The housing of workers in industrial camps has been regulated since 1933 in accord with rules adopted by the Board pursuant to Chapter 140, Wisconsin Statutes. In October 1949 the rules were modified and expanded and, excepting for the definition of the term "industrial camp," represent minimum standards for today's operator or owner. The 1951 legislature furthered state supervision of industrial camps through creation of Chapter 640, Laws of 1951, relating to the power and duties of the Board to register and certify the camps.

By statutory definition the term industrial camp now includes the site and all structures established and maintained as living quarters by the employer, or for him, or under his control and supervision, for six or more seasonal or migrant agricultural, industrial, or construction workers, and for their dependents. In addition to the legal definition of the term "industrial camp," the 1951 law requires that:

(1) any employer maintaining a camp must register such camp with the Board at least 60 days before occupancy,

(2) the Board must inspect each camp, and

(3) if the camp is found to be in compliance with its adopted regulations, the Board will issue a certificate valid for one year entitling the camp to be known and advertised as a "certified industrial camp." Penalties for violation are included.

Establishment of Chapter 640, Laws of 1951, has for the first time created a register of industrial camps operated in this state. Effort can now be directed toward all of them because their locations will be known. An opportunity is thus presented to raise the level of sanitation in housing of this type throughout the state rather than merely surveying the particular few known and contacted in the past.

Sanitary inspections will be accelerated so that at least one visit will be made to each camp each year. The ultimate objective of the sanitary inspection is, of course, the prevention or control of disease among the migrants and the community.

Very little factual information exists as to the prevalence of communicable disease among the migrant workers, although the general impression is that they are very common. Tuberculosis surveys, for example, are hampered by the brief period of time the migrants remain in one place and the difficulty of adequate follow-up. Of the diarrheal diseases only a minor proportion of cases and outbreaks are reported. Bacillary dysentery, which may be regarded as an index of the general hygiene and sanitation of a community, has been reported in several places among the migrant workers. The carrier problem and environmental sanitation are primary factors in its prevention and control. Closeness of the camps to Wisconsin communities and the intermingling of migrants with the citizenry makes it imperative that sanitary controls generally equal to those established by the state for its own citizens be established and rigidly enforced.

Migrant workers' camps differ mostly from civilian communities in the nature of their environmental conditions, especially with respect to crowding and close contacts between individuals. The adverse effect on the physical well-being caused by crowding can be reduced by improved sanitation. It is admitted that, with an organization to be controlled composed of foreign and migratory workers accustomed to living under sanitary conditions not equal to our standards of healthful environment, the enforcement of minimum housing standards is a problem that can reach acute proportions. The problem cannot be controlled by a single yearly visit of a State Board of Health representative. Local supervision is essential to the success of both the statutory and regulatory provisions for the operation and maintenance of industrial camps.

For this reason, the Board's adopted regulations charge management with the responsibility of obtaining and enforcing sanitary measures. Management is advised to contact their local community officials, especially the health officer, for assistance on camp sanitation procedures. Local health officers can and should be of more assistance on these housing and sanitation activities than has been the case in the past. While the staff of the Board will always be available for consultation on the more difficult problems, routine requests for aid should be directed to the local health authority.

Local control is, thus, the basic foundation for the sanitary housing of the migrant. Provided this control is of good quality, the returns will be measured in terms of good health.—HARVEY E. WIRTH, *Assistant State Sanitary Engineer.*

THE MEDICAL FORUM

EXPLAIN MEDICAL RELIEF FOR MIGRANT WORKERS

Dr. Sargent Named to Health Survey Panel

Chicago, June 3.—Dr. James C. Sargent, Milwaukee, chairman of the Council on National Emergency Medical Services of the A.M.A., and a member of the National Health Resources Advisory Committee, has been named to a panel on military medicine to report its findings on the health needs of the nation.

Named to a panel on rural health for the same committee was Dr. F. S. Crockett, chairman of the Council on Rural Health of the A.M.A.

GEORGE KEITH

Society Committee Draws Plans For Study of Maternal Deaths

Madison, July 15.—A special educational survey of maternal deaths in Wisconsin is scheduled to begin on January 1, 1953, according to Dr. L. M. Simonson, Sheboygan, chairman of the Committee on Maternal and Child Welfare of the State Medical Society.

The basic plan of this survey was approved by the Council last June, on the recommendation of the 1951 House of Delegates that this problem deserved detailed study.

Dr. Simonson stated that Wisconsin has nearly 50 maternal deaths each year. Under the plan being formulated by the committee, carefully selected interviewers, all obstetricians, will consult with any physician and hospital that has experienced a maternal death. All data obtained from the physician and the hospital will be submitted in confidential and anonymous form to a study committee of five obstetricians.

The study committee will report their analysis of the case to the physicians and hospitals concerned, but all factors of identification will be removed. An anonymous case report of the study will be made in the Wisconsin Medical Journal.

"It will be seen from this procedure that the purpose of the maternal death survey and study is educational and not investigational," said Dr. Simonson.

"With the cooperation of all physicians this type of study can be immensely helpful to individual practitioners and hospitals as well as the public," Dr. Simonson pointed out. "A special letter will be sent to each physician and hospital in the state as soon as the plan is completely formulated."

The committee hopes ultimately to expand the area of the study to neonatal deaths and stillbirths.

Free Reprints on Vaporizing Devices

Chicago, July 1.—The American Medical Association has announced that a reprint of a report entitled "Health Hazards of Electric Vaporizing Devices for Insecticides" will be available upon request.

Physicians interested may obtain any number of copies by writing the State Medical Society headquarters, 704 East Gorham Street, Madison.

Madison, July 1.—Migratory workers who are in need of public assistance are eligible for such assistance on the same basis as other persons, reports George M. Keith, director of the Division of Public Assistance of the State Department of Public Welfare.

Mr. Keith outlined the provisions for such care in a communication to Dr. D. E. Dorchester, Sturgeon Bay, chairman of the special medical society committee on medical problems of the migrant worker.

Highlights of his statement are:

1. **Administration of general relief is entirely in the hands of municipal or county officials (depending on the system used) and is not under the supervision of the state.**
2. **Migrant workers in need of relief (medical or otherwise) are entitled to receive such relief from the relief granting unit of government which is responsible for the furnishing of relief in the community where such workers are in need.**
3. **Medical care can be authorized under Chapter 142 for migratory workers only if the applicant has a legal settlement in some county in this state.**
4. **Physicians seeking authorization and reimbursement for services to migrant workers can usually find out the proper procedure by contacting the director of the county welfare department if the county handles general relief on a county-wide basis; or through the municipality or township relief director where the worker resides at the time he needs medical services if relief is handled on a "unit" system.**

Sections 49.02 (1) and 49.03 (1) (a) of the Wisconsin Statutes provide that the municipality or the county where the person is physically present has original responsibility for the furnishing of needed relief.

Board of Medical Examiners Sends Reminder to Chiropodists

Oshkosh, June 30.—In a recent letter to all Wisconsin chiropodists, the state chiropody examiners have called attention to the limitations of licenses in this field. The examiners are a division of the State Board of Medical Examiners. The letter read as follows:

TO ALL WISCONSIN CHIROPODISTS

In order to prevent difficulties and misunderstandings, especially among those recently engaged in practice, as to what a chiropodist is legally permitted to do in this State, we are presenting the Statutory Definition of Chiropody. While the definition is sufficiently broad to enable the practitioner to carry on this work in keeping with his education and training, there are certain clear cut limitations. It is well to note these limitations carefully so as to avoid any criticism of exceeding the legal bounds.

One recent criticism was to the effect that a chiropodist had treated a fracture by open reduction, and also that he removed a multiple tumor (not warts or verrucae).

A well trained chiropodist has the best interest of his patient at heart and uses good judgment when he refers unusual conditions, or cases outside his field, to the medical practitioner.

Section 154.01 of the Wisconsin Statutes provides as follows:

(1) "The practice of chiropody is the diagnosis or mechanical or surgical treatment, or treatment by the local applications of drugs, of the feet. BUT DOES NOT INCLUDE AMPUTATIONS OR SURGICAL OPERATIONS UPON THE FEET FOR CONGENITAL OR ACQUIRED DEFORMITIES OR CONDITIONS REQUIRING THE USE OF AN ANAESTHETIC OTHER THAN LOCAL, nor treatment of any portion or organ of the body above the feet, except that the diagnosis and mechanical treatment shall include the tendons and muscles of the lower leg IN SO FAR ONLY AS THEY SHALL BE INVOLVED IN THE CONDITIONS OF THE FEET. NOTHING HEREIN CONTAINED SHALL BE CONSTRUED TO PERMIT MAJOR SURGICAL OPERATIONS UPON THE FOOT, NOR MINOR OPERATIONS UPON THE FOOT INVOLVING VASCULAR DISEASES OR DIABETES EXCEPT UPON THE ADVICE OF ONE LICENSED UNDER 147.17, NOR THE TREATMENT OF CONDITIONS OF THE FEET INVOLVING OSTEOMYELITIS, MALIGNANCIES OR SYPHILIS, NOR CUTTING OPERATIONS INVOLVING THE BONES, LIGAMENTS, MUSCLES, NERVES, OR TENDONS OF THE FEET."

J. M. RODER, D.S.C., *President*
H. A. LARSEN, D.S.C., *Vice-President*
O. J. TRIMBORN, D.S.C., *Secretary*

Navy Announces Internship Plan

Washington, D. C., May 25.—The Navy announced that it would make 176 naval hospital internships available to medical school students graduating in 1953. Prospective navy interns must meet all requirements for a commission in the medical corps, U. S. Naval Reserve, and must serve a minimum of 24 months active duty commencing on the date they start the intern training. Appointees to the internships will be commissioned lieutenants (junior grade) and will receive the pay and allowances of that rank during their internship. Students interested in the navy internship may obtain further information by writing the Surgeon General of the Navy, Bureau of Medicine and Surgery, Navy Department, Washington 25, D. C.

Madison, July 15.—Watch your local theaters for the showing of "Your Doctor."

This short feature has been produced by RKO in cooperation with the American Medical Association.

The film explains how the doctor lives and works, and how he attempts to improve health through his county, state and national medical societies.

Watch for this film. Tell your patients to see it.

Oregon Medical Society Wins Anti-Trust Case

Supreme Court Rejects Justice Department Charges

Washington, D. C., May 1.—By a seven to one decision, the United States Supreme Court dismissed an appeal of the government against the Oregon State Medical Society.

The Justice Department had contended that the society's medical-hospital insurance plan was a violation of the Sherman Antitrust Act, an argument which the Supreme Court refused to accept.

The controversy in Oregon began in 1936 when the medical society opposed contract practice of medicine sponsored by private firms in commercial insurance companies. At that time, the medical society charged that medical treatment and service was dependent upon company approval and in some cases, the advice of physicians was disregarded.

In general, the society's contentions were upheld and the court said, "Since no concerted refusal to deal with private health associations has been proved, we need not decide whether it would violate the antitrust laws."

AMERICAN RURAL LIFE CONFERENCE TO BE HELD IN MADISON, SEPT. 17–18

Medical Society Aids in Planning Program

Madison, July 15. — A nation-wide rural life meeting of the American Country Life Association will be held September 17 and 18 on the University campus under the sponsorship of the Wisconsin College of Agriculture.

On June 21, in preparation for the nation-wide conference, a Wisconsin committee of farm men and women was called together by the president of the association, Mrs. Haven Smith of Chappell, Nebraska.

The State Medical Society is represented on the committee, which includes general farm organizations, cooperatives, health, religious, youth, educational and other rural groups. Their responsibility will be to help carry out arrangements and serve on various subcommittees.

Prof. A. F. Wileden, of the Department of Rural Sociology, is chairman of the University Committee on Arrangements for the conference.

"Not since 1930 have Wisconsin farm men, women and youth had such an unusual opportunity to rub elbows with a cross section of American rural life leaders," said Dean Rudolph Froker of the College of Agriculture.

"Ranchers of the Western Plains, corn farmers of the Middlewest, planters of the Mid-south and dairymen of the North or East will be here to discuss their common problems dealing with rural population movements, rural health, education, youth and religion.

Dr. Clark Named to President's Commission

Washington, D. C., June 15.—Dr. Donald M. Clark of Peterborough, N. H., has been named by President Truman to the Commission on the Health Needs of the Nation, filling the vacancy left when AMA Trustee Gunnar Gundersen declined to serve.

Dr. Clark recently participated in a panel discussion of the commission on general practice. He is a graduate of the University of Vermont College of Medicine and a fellow of the American Medical Association.

Republicans Take Strong Stand Against Compulsory Health Plans

Madison, July 15.—The Republican National Convention has accepted a strong plank opposing compulsory health insurance.

The health insurance plank is quoted in full as follows:

"We recognize that the health of our people as well as their proper medical care cannot be maintained if subject to federal bureaucratic dictation. There should be a just division of responsibility between government, the physician, the voluntary hospital, and voluntary health insurance. We are opposed to federal compulsory health insurance with its crushing cost, wasteful inefficiency, bureaucratic dead weight, and debased standards of medical care. We shall support those health activities by government which stimulate the development of adequate hospital services without federal interference in local administration. We favor support of scientific research. We pledge our continuous encouragement of improved methods of assuring health protection."

Magazine Tells Story of Modern Doctors

New York, July 15.—An excellent piece of public relations for the medical profession is currently being circulated in a national magazine. The story of Dr. Jeanne Bradley, a young woman interning at George Washington University Hospital, appears in the July 29 issue of LOOK. It portrays the training and sacrifices required of modern medical students.

Seek M.D. for Civil Defense Post

Chicago, July 15.—The Federal Civil Defense Administration is seeking qualified physicians for the position of Federal Civil Defense Regional Medical Director. Physicians interested in this position are urged to contact the American Medical Association, 535 North Dearborn Street, Chicago, Illinois.

RED Cross Offers to Train First-Aid Teams

Madison, June 25.—Physicians who are acting as captains of mobile medical teams in the state civil defense set-up will find promise in the recent proposal of the Wisconsin Chapter of the American Red Cross.

The Red Cross has advised that it is prepared to train first-aid instructors for local civil defense use.

Advise Physicians

It is suggested that physicians needing instructors for the training of team personnel in first-aid measures, contact local civil defense officials and local Red Cross chapter heads.

CLAIM BLANKS

A Wisconsin doctor is likely to handle more TIME claim blanks than any other company's. TIME, a leader in the accident and health insurance field, insures a large portion of the total number of persons carrying such insurance in Wisconsin.

Few doctors appreciate the great service given to their patients when these claim forms are handled promptly.

Any suggestions from you as to how our claim forms may be improved will certainly be appreciated.

• • •

The Time Insurance Company

213 WEST WISCONSIN AVENUE

Milwaukee 3, Wis

HOME-TOWN CARE AVAILABLE TO KOREA VETERANS

Physicians Should Use Form 100 as Authorization for Treatment

Madison, July 1.—Home-town medical care is now available to any veterans who served in the active U. S. military or naval forces any place in the world on or after June 27, 1950, the start of the Korean hostilities.

This announcement was made by Mr. Thomas J. Doran, director of the Veterans Medical Service Agency of the State Medical Society upon receipt of recent technical bulletins from the Veterans Administration regional office in Milwaukee.

Use Form 100

Veterans whose disabilities are presumed to have resulted from their service on or after June 27, 1950, are to be provided treatment by physicians participating in the home-town care program while the VA determines whether their disabilities actually are service-connected.

Physicians are urged to use WVMSA Form 100 for authority to treat the veteran. This procedure is designed to prevent any delay in furnishing outpatient treatment for post-Korea veterans.

To be eligible, Korea veterans must have been discharged or released from service under conditions other than dishonorable, or have been retired.

Criteria for Treatment

For medical outpatient treatment of all disabilities except active psychosis, active tuberculosis and multiple sclerosis, the disabilities may be presumed to be service-connected within one year from the veteran's discharge or release from active service on or after June 27, 1950.

Service-connection will be presumed by the VA if any of the following conditions are met:

1. **A detailed statement of the veteran as to the nature and incurrence or recurrence of the injury or disease in service which, if assumed correct, warrants a tentative conclusion that the condition requiring treatment had its origin or aggravation on or after June 27, 1950; or**
2. **Principles of sound medical judgment when applied to the existing condition warrant a tentative conclusion that such condition originated or was aggravated in service on or after June 27, 1950.**

Consideration should be given to the clinical course of the condition for which treatment is sought, its etiology, duration, and chronicity as reflecting relationship to service, the VA said. Tropical diseases, when the veteran has served in the tropics, avitaminosis, metabolic disturbances in prisoners of war, and gunshot wounds of combat veterans, are typical illustrations of cases which require little additional evidence as to service relationship.

Explain Questionable Cases

On the other hand, the VA explained, acute conditions without evidence of previous pathology, diseases having short periods of incubation, and conditions presented for surgical treatment of optional or purely corrective types without evidence of service injury should not be accorded outpatient treatment under the new announcement.

For active psychosis, the disability may be presumed to be service-connected within two years of the veteran's discharge on or after June 27, 1950.

For active tuberculosis, the disability may be presumed to be service-connected within three years of the veteran's discharge on or after June 27, 1950, providing he had 90 days of active service.

For multiple sclerosis, the disability may be presumed to be service-connected within two years of the veteran's discharge on or after June 27, 1950, providing he had 90 days of service.

VA May Discontinue Care

Veterans who meet these requirements may be provided needed outpatient treatment for medical disabilities presumed to have been incurred in or aggravated by service. While these treatments are being given, VA will determine if the disabilities actually are service-connected.

Where VA later finds out that the disabilities are not service-connected, outpatient treatment at government expense will be discontinued from that date.

Where VA finds that the disabilities actually are service-connected, outpatient treatment will continue to be authorized and the veterans, if sufficiently disabled, will receive VA compensation for the degree of their disabilities.

New Civil Defense Booklet Available

Chicago, July 7.—A new booklet entitled "Medical Aspects of Civil Defense" has just been published by the American Medical Association Council on National Emergency Medical Service, whose chairman is Dr. James C. Sargent, Milwaukee.

Contents of the book include medical aspects of civil defense, chemical defense, atomic burn injuries, radiological aspects of civil defense, nature of air raid casualties, and mental health and civil defense.

The booklet sells for 25 cents a single copy, and 20 cents per copy for orders of 100 or more. Orders may be placed through the State Medical Society, 704 East Gorham Street, Madison.

Pay Increase for Military Physicians

Washington, D. C., May 19.—Completion of Congressional action means a pay increase for all military personnel, including reserves and retired, and commissioned members of the U. S. Public Health Service.

Under the new regulations, base pay will be increased 4 per cent, and housing and subsistence by 14 per cent.

HOMEMAKERS ASK MEDICAL ADVICE IN HEALTH PLANNING

Warn Against Use of Patent Medicines

Madison, July 15.—County homemakers' groups in at least 28 Wisconsin counties have active health and safety programs, reports Mrs. David Anthony, Brooklyn, health chairman of the State Homemaker's Association.

At a recent planning conference for health chairmen of the county homemaker units Mrs. Anthony stated that "health must be a family concern. It is an ultimate factor in building world order. It must be a goal of Democracy. It has to be obtained by democratic ways."

"Wouldn't it be better to educate ourselves to prevention of this illness rather than spend enormous sums to cure patients?", Mrs. Anthony asked. "Let us guard ourselves against articles that lead to the use of drug store remedies that are harmful, misleading and risky for any illness or diet."

Confer with Doctors

She urged that all county homemaker chairmen confer with their local doctors, county nurses, 4-H leaders, leaders of local health facilities and extension representatives.

Reporting on the activities in the 28 counties having safety and health chairmen, Mrs. Anthony said that 2 counties are endeavoring to secure county nurses. Three counties stressed x-rays from mobile units during the past year. Seven counties stressed home nursing courses.

Work on Cancer

Eight counties studied First Aid. These two projects include civil defense ideas. One county had classes in prenatal care. Members from 8 counties donated to the Blood Mobile Unit with Columbia County setting the goal that each member donate blood or secure some person to donate blood.

Two counties spent time making cancer dressings. Three counties showed cancer films and held discussion periods. La Crosse County joined the survey on Effects of Smoking in relation to cancer.

MRS. DAVID ANTHONY

Dodge County will sponsor a crippled child to Camp Waubeek for 2 weeks.

Nutrition Stressed

Douglas County exerted special work on a Diabetic Clinic test. Two counties stressed immunization work. Three counties spent much time on nutrition. One county studied heart trouble and one county became interested in Arthritis troubles.

Marathon county reported having a Sanitarian who was kept busy. Two counties did special demonstration work on pasteurization of milk. Three counties conducted hearing tests. Crawford county women purchased an audiometer.

Safety is Problem

Trempealeau county gave a unique gift, a traveling plaque to the school having most number of students with dental work completed.

Vernon County homemakers did much work to promote hospital service. Along the safety line, one county studied "Electricity Dangers in the Home." Four counties became conscious of a need for a child guidance program and a mental health study.

Congress Studies Tax Relief on Pension Funds

Washington, D. C., May 25.—One of the most powerful of House Committees has taken under study a proposal solidly supported by the medical, dental and legal professions—the amendment of the revenue laws to give the self employed a measure of income tax relief while establishing voluntary pension funds.

The American Medical Association's representatives before the committee have testified that the peak earning of professional men is too short to enable such persons as physicians to set up an ample retirement plan unless a form of income tax deferment is available to them.

It was pointed out that no one provides and contributes to a pension fund for physicians or dentists and no friendly laws guarantee them minimum income in the event their patients fail to patronize them and there is no unemployment benefit for them should their business fail.

PROFESSIONAL BUSINESS SERVICE
221 State Bank Building
La Crosse, Wisconsin
Consultants on Managerial and Tax Problems.
Practice limited to Medical and Dental Professions.
References furnished on request.

Minnesota Farmers Try Deductible Insurance

St. Paul, Minn., June 22.—All Farm Bureau subscribers to Minnesota Blue Cross have agreed to pay the first $25 of their hospital care under a new deductible clause in operation since January 1.

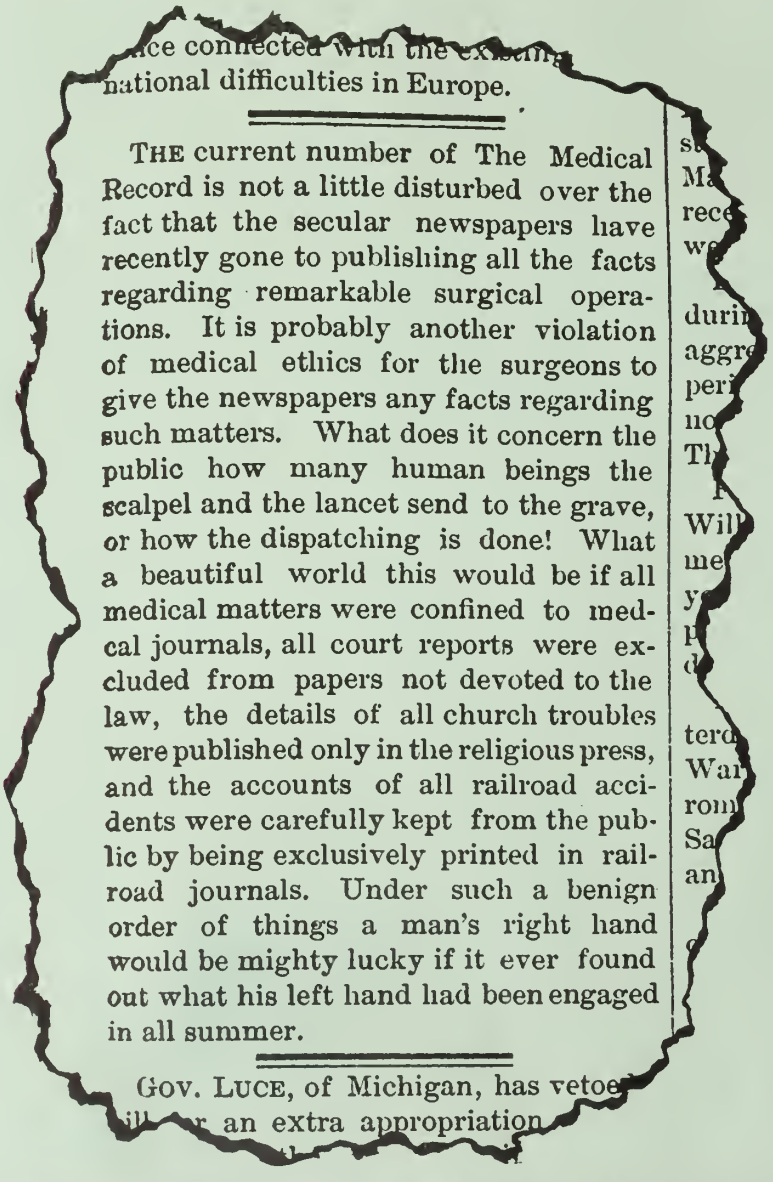
The $25 deductible feature was requested by Minnesota Farm Bureau officials and permits Blue Cross to offer a $7-a-day benefit for room, board and general nursing allowance.

County Societies Sponsor Health Poster Contests

New York, July 5.—A state-wide health poster contest in all primary and secondary schools in New York will be conducted by the Woman's Auxiliary to the State Medical Society of New York during the 1952–1953 school year.

$500 in Prizes

Entries will be divided into four classes and prizes totaling $500 in war bonds will be offered.



...ice connected with the existing
national difficulties in Europe.

THE current number of The Medical Record is not a little disturbed over the fact that the secular newspapers have recently gone to publishing all the facts regarding remarkable surgical operations. It is probably another violation of medical ethics for the surgeons to give the newspapers any facts regarding such matters. What does it concern the public how many human beings the scalpel and the lancet send to the grave, or how the dispatching is done! What a beautiful world this would be if all medical matters were confined to medcal journals, all court reports were excluded from papers not devoted to the law, the details of all church troubles were published only in the religious press, and the accounts of all railroad accidents were carefully kept from the public by being exclusively printed in railroad journals. Under such a benign order of things a man's right hand would be mighty lucky if it ever found out what his left hand had been engaged in all summer.

Gov. LUCE, of Michigan, has vetoe...
...r an extra appropriation...

A MEDICAL-PRESS CONFERENCE probably should have been sponsored by the medical society 65 years ago if the clipping shown above is any indication of widespread feeling among editors. The clipping is from the Wisconsin State Journal of June 8, 1887!

AMA Research Director Testifies on So-Called "Doctor Shortages"

Chicago, June 1.—Testifying before the President's Commission on the Health Needs of the Nation in Washington, Frank G. Dickinson, Ph.D., director of the Bureau of Medical Economic Research of the A.M.A., said that "there has not been to date a realistic study which supports any valid claim that a national doctor shortage is pending."

Dr. Dickinson said that "since people need everything, it can be safely assumed that there are unmet needs for medical services, legal services, dental services, Grade A milk, shoes, and any other goods or services which sell for a price. Since all needs are relative, it follows that all unmet needs are relative. Any approach to the study of regionalization will fail at the start if it is based upon the notion that unmet needs are absolute."

"Shortage Assumed"

Dr. Dickinson pointed out that in recent years two estimates of the doctor shortage for 1960 have been made by the federal government.

"Both of these attempts," he said, "assumed a national shortage rather than bothering to prove a national shortage."

He said further that many factors have been ignored in the two studies for making a reasonable estimate of the surplus or deficit in the 1960 supply of physicians.

"What do physicians do for people? What would more physicians do for people?

"Aging is Real Problem"

"The median age of the dying has jumped from age 30 in 1900 to age 67. Volumes are being turned out currently on the social and medical care of the aged. Although a physician must always try as hard to prolong the life of an 80 year old man as he would to prolong the life of a 10 year old boy, the formulation of national policy on the need for physicians must seriously and sympathetically consider the increasing number and percentage of older people—products of medical progress."

Truman Health Survey May Need More Time

Washington, D. C., June 8.—The Presidential Commission on the Health Needs of the Nation has begun a series of 25 panel discussions of various health problems.

Each of the panels will be composed of Commission members, special staff advisors and non-governmental professional and lay leaders.

Already panels have been held to discuss general practice, specialization, group practice and regional medical and hospital care systems. Sessions on other health fields will be continued over the next three months.

Tens of thousands of words have already gone into the Commission's minutes and the transcript is getting so long that Chairman Paul B. Magnuson is reported as saying that the Commission's life should be extended to four years. The President established the Commission last December on a 12-months basis.

12 Hospitals Being Built in State With Federal Funds

Washington, D. C., July 16.—No new hospital projects have been approved for construction in the State of Wisconsin during May, according to the Washington office of the American Medical Association.

Dr. Joseph S. Lawrence, director of the office, reported that 18 hospitals have been completed and are already in operation. Each of these received Hill-Burton grants for their construction. The 18 projects were built at a total cost of $11,300,000, including federal contributions of $4,250,000. They supply 834 additional hospital beds in the state.

Currently under construction are 12 hospitals at a total cost of $12,000,000. About $4,000,000 of this comes from federal funds. They will supply 614 additional beds.

Approved, but not yet under construction, are five hospitals to be built at a total cost of $3,400,000, including $1,500,000 in federal funds. These hospitals will provide 210 additional beds.

GENUINE ALLIGATOR physician's bag containing instruments used by the late William Fitzgibbon, M.D., Milwaukee, is the latest addition to the historical material being gathered by the State Medical Society. The bag was presented to the Society by Dr. Fitzgibbon's son-in-law, Ralph H. Schneider, Milwaukee. Dr. Fitzgibbon was a native of Fond du Lac county and a graduate from Wisconsin Physicians and Surgeons College, now Marquette University School of Medicine, in 1897. He was a member of the Society's "50-Year-Club."

HERE'S A SUGGESTION FOR KEEPING PATIENTS INFORMED "ABOUT FEES"

Chicago, June 3.—Survey after survey has revealed that many patients think medical fees are too high and the doctors make too much money.

A Charlotte, North Carolina physician, Dr. David G. Welton, has come up with a suggestion for explaining fees that may help in the improvement of individual medical public relations.

He has prepared an attractive leatherette folder stamped "About Fees" which he keeps in his waiting room. Inside the cover, he has printed a page and a half message, written in a friendly fashion stating that doctors are dedicated to the care of the sick and to this end must maintain fully equipped offices and competent personnel.

"No doctor should aspire to become wealthy on the care of the sick; but it is the natural desire and ambition of very man to marry, to have a home, to raise children, and to put something aside for his old age," continues the message.

"It is my desire to give patients a clear understanding of the cost involved in any illnesses and I always appreciate the opportunity to discuss these and other costs with the patient or a responsible member of the family."

"If, for some reason, a patient is unable to pay the reasonable fees I have established, then it shall be my purpose to do everything within my power to furnish him with the best medical care at a fee which will not produce an undue hardship or impossible financial burden upon him or his family."

"Through our medical association, my colleagues and I accept the responsibility of providing needed medical care for everyone, regardless of inability to pay."

CIVIL DEFENSE FILMS AVAILABLE TO WISCONSIN PHYSICIANS UPON REQUEST

Madison, June 15. — The Wisconsin Office of Civil Defense reports the availability of a large number of films for loan or purchase for the education and training of physicians and mobile medical team personnel.

The films may be purchased on a matching fund basis—50% local and 50% federal—or in many instances may be obtained on loan from Army film libraries.

Physicians interested in obtaining any of the films listed below are urged to contact the Wisconsin Office of Civil Defense, State Capitol, Madison, Wisconsin, or the Committee on Civil Defense, State Medical Society of Wisconsin, 704 East Gorham Street, Madison, Wisconsin.

The following films are of interest to physicians and personnel in mobile medical teams:

1. *Duck and Cover*—10 minute, black and white, sound—introduces to children basic rules of self-protection in an atomic attack.

2. *Survival under Atomic Attack*—10 minute, black and white, sound—scenes of devastated Hiroshima illustrate blast, heat and radiation effects of atomic bombing. Six basic rules of survival are discussed. The citizen is instructed in ways to act at home, at work, outdoors, walking, driving, with or without advance warning of an atomic attack.

3. *What You Should Know about Biological Warfare*—10 minute, black and white, sound. Points out defense measures to be taken against possible enemy attack with germs or other biological weapons. Recognizes both rural and urban possibilities of this type of attack.

4. *Emergency Action To Save Lives*—Many first aid actions which can be taken to save lives of civilian casualties in wartime—includes protection against burns, shock, wounds, fractures and asphyxiation. Still in production by Federal Civil Defense Authorities.

5. *What You Should Know About Nerve Gas*—Still in production by federal authorities.

6. *Atomic Medical Cases, Japan, World War II*—37 minutes, black and white, sound—for professional audiences.

7. *Bomb Blast and Burns*—13 minutes, color, sound. Explains by use of animation how an explosion causes serious burns, internal injuries and wounds from falling fragments.

8. *First Aid in the Prevention of Shock*—26 minutes, black and white, sound. Produced by the Signal Corps, this first aid film deals with several types of wounds, including burns, fractures, head and body injuries and shows how shock may develop from each and how to prevent it.

9. *Medical Aspects of Nuclear Radiation*—20 minutes, color, sound. Made for the Armed Forces Special Weapons Project, film is aimed at lay audiences rather than the medical profession. Shows through the use of both live action and animation what nuclear radiation is and how the nuclear damage of atomic weapons affects the human body.

Dr. Pauly Named Director of CD

Madison, June 27.—Dr. Roman C. Pauly, Sheboygan, has been appointed Area Medical Director of Division C in Civil Defense Area Three.

This includes Calumet, Manitowoc and Sheboygan counties.

Doctor Pauly will shortly call orientation meetings for team captains, deputies, and business managers of civil defense mobile teams in that area.

U. S. Has Record Number of M.D.s

Chicago, June 29.—The number of physicians in continental United States stood at an all time high at the end of 1951.

According to the annual licensuary report of the A.M.A., the United States had a total of 211,680 physicians at the end of 1951. This represented a net increase of 2,640 doctors in the United States during that year.

President's Commission Plans "Field Trips"

Washington, D. C., May 6.—Dr. Paul Magnuson's commission on the health needs of the nation has scheduled meetings to consider the training of physicians, health of the aging, mental health, care of the chronically ill, research and industrial health.

Speaking to a group in Baltimore, Doctor Magnuson said commission members are considering making a series of field trips "to get a close, realistic view of both the good and the bad in medical care today."

Among the trips under consideration is one to rural Mississippi, and another to a defense area.

AMA Members Have Choice of 9 Journals

Madison, June 15.—Nine American Medical Association specialty publications are available to the members of the American Medical Association in lieu of the Journal of the American Medical Association.

Heretofore, many physicians who would prefer a specialty journal to the J.A.M.A. have been unaware of their ability to obtain any one of the nine publications without extra cost to themselves.

A member may select any one of the journals listed below:

- A.M.A. Archives of Internal Medicine
- A.M.A. American Journal of Diseases of Children
- A.M.A. Archives of Dermatology and Syphilology
- A.M.A. Archives of Neurology and Psychiatry
- A.M.A. Archives of Pathology
- A.M.A. Archives of Surgery
- A.M.A. Archives of Otolaryngology
- A.M.A. Archives of Ophthalmology
- A.M.A. Archives of Industrial Hygiene and Occupational Medicine

The change may be accomplished simply by writing the Subscription Department, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois. Merely explain that you wish to substitute the journal of your choice for the J.A.M.A.

Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

Acquirement of Resistance to Noxious Agents

In Korea, the routine application of a 10 per cent DDT powder to military personnel has resulted in an increase in infestation by body lice instead of the highly desired complete eradication.[1] The diluent employed was chalk, which is commonly used for this purpose. The active chemical, DDT, was demonstrated to be normally effective on susceptible organisms grown in culture for test purposes. Therefore, the failure of the drug was due to an acquired increased resistance or tolerance on the part of the lice themselves.

In a certain group of segregated individuals, the percentage of infected persons dropped from 68 per cent before treatment to 17 per cent eight days after treatment, but from this time the percentage began to rise, reaching to 38 per cent by the fourteenth day, all in spite of the continued presence of the insecticide.

The common housefly is known to become relatively tolerant to DDT after successive exposure through several generations. This strain of flies could tolerate approximately 200 times as much DDT as unexposed specimens of the same strain. Flies have been shown to develop a significant tolerance also to benzene hexachloride and pyrethrum, as well as to other insecticides. Another interesting and significant feature is illustrated by the observation that a number of insecticides are less effective in warm than in cool weather, and also that high humidity reduces the efficiency of these substances. Mosquitoes, like flies, are also known to become relatively tolerant to certain insecticides.

Several species of pathogenic bacteria are already known to possess the capacity of developing an increased tolerance to one or all of the available antibiotics; thus, several strains of staphylococci have been found to become quite resistant to penicillin, presumably due to increased production of penicillinase,[2] and 12 different species of bacteria have been found capable of developing a very significant tolerance to aureomycin and to terramycin but somewhat less to chloramphenicol and to neomycin. Some cross-tolerance, i.e., tolerance developed by one drug carried over towards another drug, has been observed.[3] Staphylococci develop a marked tolerance also towards the sulfonamides, probably due to increased production of para-amino-benzoic acid.

C. Phillip Miller[4] has reported a most striking observation regarding a strain of meningococcus. This strain was grown on culture media containing progressively increasing amounts of streptomycin with the many successive transfers. The meningococci became progessively less and less inhibited by the drug until finally the drug did not inhibit the bacteria at all but instead had become a vital necessity.

In our own laboratory we have observed the well known "arsenic-fastness," or tolerance to arsenical drugs, developed in trypanosomes. This phenomenon, long ago, was described by Paul Ehrlich.

Traditionally, aborigines of an isolated territory have become relatively tolerant to their own diseases to which they have been exposed for untold years. Many of these same people, "natives," on the other hand, succumbed in high percentages to other diseases introduced by newcomers to their land. H. Gideon Wells, the pathologist, frequently used the expression—"highly syphilized peoples"—referring to peoples much less susceptible to the ravages of syphilis than peoples of lands where this disease had not previously existed. Tuberculosis appears to fall into line as causing a more or less generally rising tolerance among peoples exposed throughout several generations. These human examples of racial tolerance in man may be more apparent than real in respect to inherent resistance capacity.

Most known living organisms have, of necessity, some degree of facility for adaptation which may be accentuated or increased in the progeny by the processes of survival of the fittest, as postulated long ago by Darwin. This basic concept thus comes to focus sharply when we note that man's efforts to destroy "pests" appear to be met by the survival drive of these pests through continuous processes of compensatory adaptation.

The situation presented by these few examples points to a simple postulation. Exposure of living things to untoward conditions demands the development of some grade of effective tolerance or adjustment—or face inevitable extinction, the fate of the relatively non-adjusting dinosaur.

Finally, it should be obvious that in the employment of antibiotics, it behooves the physician to employ these agents only in instances of real necessity, lest by inadequacy of treatment there be developed resistant strains which when passed on to other persons may well establish infections resis-

tant to chemotherapy. Man has survived up to the present time by developing within himself protective processes against invading organisms and hence this self-protection must be fostered as much as safety permits. *Man cannot live by antibiotics alone.*—A. L. TATUM, M. D.

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POSTGRADUATE CLINIC ON HEART DISEASE ANNOUNCED

Dr. Ovid O. Meyer, chairman of the postgraduate education committee of the Wisconsin Heart Association, announces a postgraduate clinic on heart disease for Wisconsin doctors.

The Faculty: Paul D. White, M. D., Consultant in Medicine, Massachusetts General Hospital, Boston, Massachusetts; Executive Director, The National Advisory Heart Council.

Alfred Blaloch, M. D., Professor of Surgery and Director of the Department of Surgery, Johns Hopkins University School of Medicine, and Surgeon in Chief, Johns Hopkins Hospital, Baltimore, Maryland.

The Time: Identical clinics will be held at the Marquette University School of Medicine in Milwaukee on Wednesday, October 22, and at the University of Wisconsin Medical School Auditorium in Madison on Thursday, October 23.

Description: Doctors White and Blaloch will conduct clinics in the afternoon on subjects furnished to them at the two medical schools. Each will give a formal presentation in the evening.

The title of Doctor White's talk will be "Three Medical Eras."

The title of Doctor Blaloch's presentation will be "The Surgical Treatment of Certain Types of Cardiovascular Disorders."

These clinics are made possible through a special grant from the Wisconsin Heart Association and no fee will be charged. All members of the medical profession in Wisconsin are welcome.

Clinicopathologic Conference

Editors—W. A. D. ANDERSON, M. A., M. D., Marquette University School of Medicine, Milwaukee and D. M. ANGEVINE, M. D., University of Wisconsin Medical School, Madison

PRESENTATION OF CASE*

History: This 31 year old gravida I, para 0, was 26 weeks pregnant and had a history of known diabetes for 14 years. She entered the hospital because of nausea and vomiting plus an upper respiratory infection and kidney infection, all of which had been present for two weeks. Prior to that her pregnancy had been uneventful. She had taken 80 units of protamine zinc insulin since 1947 and had not had to change her dosage during her pregnancy. She had never been in insulin shock or diabetic coma. Her diet was roughly 2,000 calories. She had been hospitalized elsewhere for the combined kidney and upper respiratory infection plus the poor control of her diabetes. During her stay in the hospital, she had been treated with "some yellow capsules." Other symptoms were the presence of dysuria and backache recently. Her average weight before her pregnancy was 135 pounds; three weeks prior to admission she weighed 142 pounds; on admission she weighed 119¾ pounds. Past medical history was essentially negative except for an appendectomy and left oophorectomy. Family history revealed that the maternal grandmother had had diabetes.

Physical Examination: At the time of admission the patient was a thin, acutely ill white woman. Pertinent physical findings included a blood pressure of 180/120, pulse of 100, and respirations at 26 per minute. Temperature was 99.2 F. Abdominal examination revealed a pregnancy compatible with 26 to 27 weeks gestation; the fetus was in left occiput transverse position; fetal heart tones were good. The patient had bilateral costovertebral angle tenderness. She had no edema. Funduscopic examination revealed very minimal changes of diabetes but no hypertensive changes. Almost immediately after admission to the hospital, while getting 10 per cent glucose intravenously for her toxemia, the patient went into what we felt was insulin shock. The intravenous feeding was speeded up, and she was given orange juice with sugar orally. The response to this was good.

Laboratory Studies: A catheterized urinalysis showed .025 per cent albumin, with 12 to 14 white blood cells and 3 granular casts. Her hemoglobin was 11.2 Gm., red blood cell count, 3,200,000 and white blood cell count 18,300 with 85 per cent polymorphonuclears. Her fasting blood sugar was 52 mg. per cent and nonprotein nitrogen was 79 mg. per cent. Carbon dioxide-combining power was 48 volumes per cent.

Course: Because we agreed with the impression of a pyelonephritis, the patient was given terramycin by mouth and streptomycin intramuscularly. Her insulin dosage was reduced to 50 units, but on the second day she again had an insulin shock, and the third day we reduced the insulin to 30 units of NPH. Shortly after admission she began to vomit and was unable to retain anything taken orally from that time on. On her third day, because of poor urinary output, it was decided to stop the administration of streptomycin. Her blood pressure remained elevated. Her temperature never went over 99.2 F. A chest plate was negative. Axiopulpal and lateral view of the abdomen were reported as showing (1) intrauterine pregnancy at 6½ months, (2) probable renal calculus on the left, and (3) arteriosclerosis noted in the vessels of the maternal pelvis. The nonprotein nitrogen rose daily so that on the fourth day it was 104. At that time the carbon dioxide-combining power was 36 volumes per cent. Urinary cultures showed Staphylococcus albus and gram negative organisms belonging to the coli-aerogenes group. Her intake was 4,000 cc., and her output was 1,800 cc., which was better than previously. The afternoon of the fourth day she again went into insulin shock, became semicomatose and had some twitching. She was given 30 Gm. of glucose using 50 per cent glucose intravenously and then 1,000 cc. of 5 per cent glucose. She showed only moderate clinical improvement. At that time the abdominal wall seemed to have some generalized brawny edema. She was complaining of backache. It was then decided to terminate the pregnancy. Therefore, a classical cesarean section with tubal sterilization was done. The infant weighed 3 pounds, 1 ounce and survived. She had a retrolental fibroplasia. The patient withstood the procedure well. Postoperatively she continued to complain of severe backache and vomiting. Her blood pressure remained elevated. On the day following surgery the nonprotein nitrogen was 102 mg. per cent, creatinine 7.8, and carbon dioxide-combining power 36 volumes per cent. Blood sodium, chloride, and potassium levels were normal. Her urinary output was 1,350 cc., and it contained .55 Gm. of albumin per liter. She had no insulin the day following surgery. Her intake was 3,000 cc. That evening she had some distention. A gastric tube was inserted, and 400 cc. of a black, thin, watery fluid was removed, and the Wangensteen suction was continued. The second day following surgery she started to have hematuria. Her nonprotein nitrogen went to 148 mg. per cent, blood sugar 144 mg. per cent, and creatinine 7.6 mg. Clinically she seemed to be doing very well. The

*From the State of Wisconsin General Hospital and University of Wisconsin Medical School.

output was 1,300 cc. Early in the morning she started to complain of feeling dizzy and weak and within ten minutes had expired.

Clinical Discussion

Dr. O. O. Meyer: The patient lost weight from 142 to 119 pounds, and as she had nausea and vomiting, I am inclined to attribute the weight loss to this, but there may be another explanation of which I am not cognizant. The point is made in the physical examination, however, that she had no edema, and that, as a negative point, is worthy of consideration because of the toxemia that existed.

On physical examination we had a decidedly ill individual who had a low grade fever, and so far as we can tell, it was never above 99.2 F., who had hypertension, and very significant hypertension, and yet her eye grounds did not show a great deal of change which suggests that her hypertension was not of very long standing. The hypertension which existed may be a part of this pregnancy, or it may have preceded it, but I have no way to tell which from the clinical data which are available. She had costovertebral angle tenderness which was bilateral, and I think we can attribute it to kidney disease.

The urine analysis showed albumin and casts and some white cells. She had anemia. The nonprotein nitrogen was distinctly elevated, 79 mg., and as time passed there was a mounting retention of nitrogen waste products, and in association the carbon dioxide-combining power became increasingly low, and she had acidosis. She may have had acidosis because of lack of control of her diabetes. More likely that is not the case, for regularly in uremia acidosis occurs because of the disturbance in the excretion of acids and synthesis of alkali.

A pregnant diabetic case, Priscilla White reports, has a lowered renal threshold for glucose and is likely to become unstable and have glycosuria, but a woman who is pregnant and has diabetes may in rare instances require less insulin because of the fetal pancreas functioning. Usually the requirement is likely to be greater, and what is more, the patient often requires frequent doses of insulin rather than single doses of long acting insulin.

There was agreement that the patient had pyelonephritis and so she was given terramycin and streptomycin. The organism was of the coli-aerogenes group and Staphylococcus, and presumably the coli-aerogenes organisms were the important pathogens.

Increased sensitivity to insulin developed in this patient, and I will discuss the possible reasons which I think may be responsible a bit later. We have some more information from the laboratory. The chest roentgenogram was negative. A renal calculus was demonstrated in the x-ray of the abdomen. Now, it is emphasized by most urologists, I believe, that often pyelonephritis and other urinary tract infections are difficult of control because so often there is obstruction present or there is disease, renal calculus for example, as presumably existed here. I would guess that this renal pathology in the form of pyelonephritis persisted, and the renal calculus may have been an important reason for its persistence.

Then, this 31 year old woman had arteriosclerosis in the vessels of the pelvis, a thing that occurs in young individuals most often when they are diabetics. Actually, because it existed raises one of the possible considerations as to the mode of sudden termination. When she began to have hypoglycemic reactions, her insulin dosage was repeatedly reduced, and then edema did develop, brawny edema of the abdomen, and that probably was ominous and of significance as a part of the toxemia. An infant was delivered by cesarean section weighing 3 pounds, 1 ounce, and she survived.

The patient then had severe backache and vomiting. We have evidence of progressive azotemia with the creatinine as high as 7.8 and the nonprotein nitrogen above 100 and ultimately as high as 148 mg. per hundred cubic centimeters of blood. A creatinine level as high as that in a patient with chronic renal incompetence nearly always means that recovery is not to occur, but you may have creatinine at this high level in acute renal incompetency and yet the patient may survive.

Why should this patient have had progressive lessening of her need of insulin? We know that she had had large doses of insulin since 1947. In other words, there was no recent increase in her insulin requirement which was now again lessening because of clearing of the infection. We know that infections may enhance the requirements for insulin and the subsidence of infection may permit its reduction. We know that in both animals and human beings complete pancreatectomy in one previously diabetic will usually lessen the requirement for insulin. The need is usually for only 30 to 40 units of insulin and rarely more if the pancreas is completely ablated so that pancreatic disease itself may have existed to account for her lessened insulin requirements. That is not likely.

The pituitary with its production of ACTH is a distinct possible factor. Houssay showed that hypophysectomy lessened the insulin requirement in pancreatectomized dogs, so that, if we should have disease of the pituitary here that has developed rather acutely, the hypersensitivity to insulin in this diabetic individual might thus be explained. Disease of the adrenals is another consideration. The pituitary effect may be through the adrenals. Although the pituitary may have a specific effect by inactivating hexokinase, thus being diabetogenic, the pituitary effect might be through the adrenal, hence we must think of the possibility of adrenal insufficiency that has developed relatively acutely so that the patient has become more sensitive to the insulin that was being administered. We have no information as to what happened to the blood pressure. We do know that the blood pressure was high initially and that it remained high. However, it need not fall appreciably even though there be adrenal insufficiency.

One wonders about the explanation for an interesting change in diabetic course of the patient. There may be some other explanation that I have not considered. In any event, she was seemingly doing well clinically after her operation, although chemically she was not when she suddenly died.

The description of this final affair includes dizziness and weakness and within 10 minutes she expired. What are our considerations? Well, she had arteriosclerosis, she was a diabetic, and maybe she had a coronary occlusion. Women do have coronary occlusion, rarely at this age, but it can occur, especially if they are hypertensive. I do not think that that is it. She might have had a pulmonary embolus which was massive and caused sudden death. Usually, this occurs more than two or three days postpartum or postoperative. The protocol is not clear, but I gather that she died on either the second or third postoperative day. Usually, they are beyond the fifth postoperative day when they die suddenly from pulmonary embolism, and then the patient suddenly gasps, has great dyspnea, it may be only for a moment, and then drops dead. I do not think that that was it, or we would have been told that she became very dyspneic and cyanotic.

She may have died merely because of renal incompetence with cardiac failure. Incidently, she did have an earlier episode where she had a convulsion, and maybe it was insulin convulsion, and possibly it was a uremic convulsion, and perhaps it was the convulsion of eclampsia; I do not know. We know that she had what appeared to be uremia. She had pyelonephritis, and she had a pulmonary infection. Both Doctor Angevine and Doctor Brown told me she had infection, although you would not suspect from this protocol that she had a great deal. The coli-aerogenes group can produce septicemia or endocarditis and can produce fatal disease. Now one may seek the obscure; the specific etiologic agent will be difficult to establish.

However, there is just one point that everyone of us has become increasingly conscious of in the last year or more and that is the matter of giving antibiotics to get rid of bacteria and then having another infecting agent take over. That infecting agent usually affects the mouth, the vagina, or the rectum. Often it is a mild infection which may last for weeks and be very uncomfortable for the patient, but occasionally it is more than that. There may be involvement of the meninges or the lungs with a fungus or any of several fungi, but the one we are seeing most often is Monilia albicans. It may, I suppose, be sporotrichosis, but Monilia infection has been our most frequent finding in these patients who have had antibiotics for a long period of time.

What was found at postmortem examination? The hemorrhage at the end may have been blood in the stomach with gastritis of uremia; petechiae in nephritis are common, of course; and there was hematuria which may have been due to capillary change. I suspect that there will be shown to be extensive infection. I do not know the etiologic agent, but I suspect a fungus. They found, I think, seriously diseased kidneys with capillary endothelial change that was marked. They found glomerular and tubular change in the kidneys. This patient had hypertension. I do not know whether she had had it for a long time or not, and incidently, I did not touch upon the fact that patients with Kimmelstiel-Wilson's syndrome tend to have a lessened requirement for insulin as the disease progresses. However, the lessened insulin requirements were too acute for that, I believe. The patient may have had intercapillary glomerular sclerosis if she had had long-standing hypertension with the diabetes. If there was hypertension only during this pregnancy, then I would think not. There will be shown some liver change, probably a perilobular necrosis, because of the toxemia of pregnancy. I think that she had had serious cardiovascular or renal disease and probably died because of an extensive and somewhat overwhelming type of infection to which there was little febrile response. She did have leukocytosis which may have been explained by her pyelonephritis and respiratory infection.

X-ray: The chest films, as stated in the protocol, were negative. The axiopulpal view of the abdomen showed a fetus approximately 6½ to 7 months in the uterus. The position was approximately transverse. There were a few calcified vessels in the pelvis which could be seen well. There was a small irregular calcific density in this area which could barely be made out in the projection in the general region of the upper pole of the kidney. This calcific density was seen well back and was felt to be calculus in the upper pole of the kidney.

Dr. J. W. Harris: I should explain that, in spite of the fact that I know the postmortem findings, I am still somewhat at a loss to explain the immediate cause of death. There are a number of points in this patient's case of obstetric interest and importance.

First of all, the patient was a severe diabetic of long standing, and during most of her pregnancy it was not possible to control her diabetes adequately. It is becoming increasingly apparent that severe diabetes, particularly of the juvenile type, when complicated by pregnancy is becoming a very great hazard to both mother and child. Since Dr. Priscilla White first brought it to our attention, we have studied all pregnant diabetics for atheromatous changes in the pelvic vessels, and this patient exhibited the most marked degree that I have seen.

In the second place, the patient developed a toxemia, a common complication of pregnancy in diabetics. While one cannot be sure, my impression is that the toxemia was of the pre-eclamptic type. The absence of blood chemical changes and evidences in the eye grounds would speak against one of the chronic toxemias. The convulsive seizures were not typical of eclampsia and were more likely due to the diabetes.

The delivery by cesarean section was chiefly a procedure of last resort and was done largely in the hope that a living baby might be obtained.

The question has been raised as to pulmonary embolism. While the third stage of labor and the puerperium are favorite times for emboli to occur, certainly the patient did not in any way impress us that this was a factor.

The question of acute cortical necrosis of the kidney was debated, and certainly many clinical manifestations in this case suggested it.

From a clinical point of view, the terminal events were not at all characteristic of any type of infection common in obstetrics.

Necropsy Findings

Dr. John W. Harman: The individual was normal externally in all respects. The viscera of the chest were normal. I may say that there was no evidence microscopically of embolism of the type of which Doctor Harris spoke such as occurs during childbirth, so we can exclude that at once. The principal pathology as you suspected from the discussion is confined to the kidney. The kidneys were considerably enlarged. Each weighed approximately 300 Gm., which approximates twice the normal size. They were studded with numerous small abscesses, glaring white in color. On hemisection of the kidney all the pyramids of the kidney were completely necrotic. Culture was taken of both the kidneys to determine what the infecting organism was at the time of death.

The gross picture of the kidney showed effectively the wide distribution and the variability in size of the numerous abscesses that were scattered throughout the entire substance of both organs. A picture taken through the middle of the kidney in toward the pelvis demonstrated first of all the injection and congestion of the pelvis associated with a pyelonephritic condition on both sides. As well as that, at the upper pole in the yellow area the necrosis of the pyramids could be seen. This condition is commonly called papillitis necroticans renalis and is frequently found in pyelitis associated with diabetes mellitus.

A microscopic picture of the clear cut zone demarcation between a necrotic area lying in a renal papilla and the relatively normal renal tissue about it indicated that the terminal point of the exodus of the urine into the renal pelvis was disturbed considerably by the sloughing off and necrosis in that area. There was distributed through the pyramid clumps of yeast-like organisms easily stained by the MacManus periodic acid stain. These organisms, identified by culture as Monilia albicans, not only involved the necrotic area, but they were in some instances found ascending the tubules and occurring in the cortical abscesses.

There was a hyaline arteriolar change also so that the hypertension may have been associated with this pre-existing renal sclerotic disease. As well as that, there was a minimal sclerosis involving the glomeruli which was interpreted as a diffuse variety of Kimmelstiel–Wilson's glomerulosclerosis. The section taken through the glomerulus demonstrated the early sclerotic change of a patchy type in the glomerulus but showed as well the efferent arteriole in which there was a specific deposition of hyaline as compared to other forms of sclerotic changes in the kidney.

The diagnoses, therefore, which we reached in this case were:

Acute bilateral pyelonephritis
Bilateral hydroureter
Monilia albicans infection
Cystitis hemorrhagica
Thrombosis of the ovarian vein, right
Arteriosclerosis, pelvic vessels, extreme
Kimmelstiel–Wilson's glomerulosclerosis
Papillitis necroticans renalis

The uterus was in a state as you would suspect as a result of the previous surgery, but nothing exceptional in the way of advanced pathology. The glomerular lesions were consistent with a very early Kimmelstiel–Wilson's disease. There was an arteriolosclerosis of the kidney, perhaps sufficient to lead to hypertension of the degree found here for a limited time.

Death, we feel, was instrumented by means of the renal lesion. The causative organism here in the early stages was the coliform organism itself. The application of antibiotics may have been part of the picture of change bringing about the supplanting of the coliform organisms by the Monilia. The event of the papillary necrosis was not peculiar to the appearance of the moniliform infection because it has been found frequently in the past in cases in which the moniliform organism was not the organism primarily responsible for the disease. Therefore, the sequence of events would be the diabetes, the pregnancy, the usual hydroureter and hydronephrosis, ascending infection by the typical organism causing an ascending infection, the application of antibiotics, the alteration of the type of organisms, and the supervention of the papillary necrosis irrespective of the type of organism which finally was found at the time of autopsy.

Dr. D. M. Angevine: I have nothing to add to Doctor Harman's discussion but am a little disturbed that Doctor Harris is not satisfied with the anatomical cause of death.

Dr. J. W. Harris: Well, what I meant was that none of these things separately to my way of thinking would explain death at that time, and there is still a lot about it with which I am not satisfied.

Dr. D. M. Angevine: In a uremic patient with this amount of infection, I suspect that the toxic element may have played a role as well.

Dr. O. O. Meyer: Was the brain examined?

Dr. D. M. Angevine: The brain was not examined because we did not have permission to do so.

THE 1952 ANNUAL MEETING

W. S. BUMP, M.D.
Chairman, Council on Scientific Work

T. O. NUZUM, M.D.
General Program Chairman

P. A. MIDELFART, M.D.
Chairman, Scientific Exhibits

S. A. MORTON, M.D.
Chairman, Special Demonstrations

MILWAUKEE—OCTOBER 6-7-8

The Council on Scientific Work is pleased to invite you, as a member of the State Medical Society of Wisconsin, to attend the 1952 Annual Meeting scientific sessions described on the following pages.

In preparing this program the Council on Scientific Work has kept in mind the value of teaching in small, informal groups, to supplement the scientific lectures in the form of general assemblies. On the basis of interest shown in the teaching demonstrations featured at the 1951 meeting, this type of presentation has been scheduled again this year.

Those of us who have had the pleasure of developing this program in cooperation with Doctor Nuzum, as general program chairman, feel that we have succeeded in formulating a scientific meeting which will provide many benefits to those in attendance. We hope you will share the experience with us through your attendance and active participation in the various parts of the program which have been planned so as to provide audience discussion.

If you have not already made your reservations for the luncheons and the Annual Dinner you are urged to do so immediately, as facilities for each of these functions are limited.

W. S. BUMP, M.D.
Chairman, Council on Scientific Work

SUMMARY OF SCIENTIFIC SESSIONS

Monday, October 6

9:00 a. m.: SPECIAL TEACHING DEMONSTRATIONS: **Toxemias of Pregnancy,** Fractures, Respiration Methods, X-Ray Interpretations ("Scout Film of the Abdomen")

10:15 a. m.: HOSPITAL STAFF CONFERENCES: Children's Hospital (Arthritis, Nephrosis, Encephalitis) . . . VA Hospital Staff (Diseases of the Pancreas) . . . Milwaukee Hospital Staff (Medical and Surgical)

12:15 p. m.: LUNCHEONS (See page 710 for schedule)

2:00 p. m.: GENERAL SESSION: **Operation for Coronary Artery Disease:** Claude S. Beck, M. D., Cleveland . . . **Portal Cirrhosis:** Jacob K. Berman, M. D., Indianapolis . . . **Diagnosis and Treatment of Emotional Illness:** Annette C. Washburne, M. D., U. of W. . . . **Treatment of Thyrotoxicosis with Radioactive Iodine:** E. C. Albright, M. D., U. of W.

8:30 p. m.: SMOKER AND PROFESSIONAL ENTERTAINMENT

Tuesday, October 7

9:00 a. m.: SPECIAL TEACHING DEMONSTRATIONS: **Breech Extraction,** Fractures, X-Ray Interpretations ("X-Ray Diagnosis of Fractures"), Respiration Methods

10:15 a. m.: SPECIAL SYMPOSIA: Internal Medicine and Obstetrics and Gynecology (Instead of Section Meetings in These Fields)

1. Symposium on **Diagnosis and Therapy of Infectious Diseases**
   Participants: Wendall Hall, M. D., U. of Minn.
   Burton A. Waisbren, M. D., Marquette
   John W. Brown, M. D., U. of W.
2. Symposium on Obstetrics and Gynecology
   Participants: Allan C. Barnes, M. D., Columbus, Ohio **(Use of Sex Hormone Products)** . . . Sprague H. Gardiner, M. D., Indianapolis **(Psychosomatic Aspects of Sterility)** . . . D. N. Danforth, M. D., Evanston **(Borderline Pelvic Contractions)**

12:15 p. m.: LUNCHEONS (See page 710 for schedule)

2:00 p. m.: GENERAL SESSION: **Protein Needs in Children:** E. T. McEnery, M. D., Chicago . . . **Dietary Management of the Pregnant Patient:** Allan C. Barnes, Columbus, Ohio . . . **Hypoglycemias:** W. W. Engstrom, M. D., Marquette . . . **Parenteral Alimentation:** Paul R. Cannon, M. D., Chicago . . . **Psychosomatic Gynecology:** Sprague H. Gardiner, M. D., Indianapolis

7:00 p. m.: ANNUAL DINNER

Wednesday, October 8

9:00 a. m.: SPECIAL TEACHING DEMONSTRATIONS: **Antidote to Fetal Depression Induced by Obstetric Analgesics,** Fractures, X-Ray Interpretations ("Common Lesions of the Skull"), Respiration Methods

10:15 a. m.: SPECIAL SYMPOSIA: Pediatrics, Surgery, and Radiology (Instead of Section Meetings in These Fields)

1. **Developmental Requirements in Childhood**
   Participants: John A. Anderson, M. D., San Francisco
   E. S. Gordon, M. D., U. of W.
   Reynold A. Jensen, M. D., U. of Minn.
2. **Significant Surgical Problems**
   Participants: Hayes Martin, M. D., New York City
   Robert Elman, M. D., St. Louis, Mo.
3. **Radiologic Problems**
   Myelography: Harold O. Peterson, M. D., Minneapolis
   Five important case studies by Wisconsin radiologists

12:15 p. m.: LUNCHEONS (See page 711 for schedule)

12:15 p. m.: LUNCHEON AND SECTION MEETING ON OPHTHALMOLOGY AND OTOLARYNGOLOGY

2:00 p. m.: CLOSING GENERAL SESSION: **Degenerative Diseases of the Hip:** Chas. Ihle, M. D., Eau Claire . . . **Electrolyte and Nutritional Balance:** Robert Elman, M. D., St. Louis . . . **The Pathogenesis of Rheumatic Fever:** John Anderson, M. D., San Francisco

SOME OF THE OUT-OF-STATE GUEST SPEAKERS

ALLAN C. BARNES, M.D.
Prof. and Chr., Dept. of Ob. & Gyn., Ohio State Univ., Columbus

CLAUDE S. BECK, M.D.
Prof. of Cardiovascular Surgery, Western Reserve Univ., Cleveland

JACOB K. BERMAN, M.D.
Assoc. Prof. of Surgery, Indiana School of Medicine, Indianapolis

PAUL R. CANNON, M.D.
Prof. and Chr., Dept. of Pathology, Univ. of Chicago

ROBERT ELMAN, M.D.
Prof. of Clinical Surgery, Washington Univ. School of Medicine, St. Louis

JOSEPH S. HAAS, M.D.
Asst. Prof. of Ophthalmology, University of Illinois, Chicago

WENDELL H. HALL, M.D.
Clinical Asst. Prof. of Medicine, Univ. of Minnesota, Minneapolis

A. C. HILDING, M.D.
Clinical Prof. of Ophthalmology and Otorhinology, Univ. of Minn., Minneapolis

HAROLD O. PETERSON, M.D.
Clinical Assoc. Prof. of Radiology, Univ. of Minn., Minneapolis

[SEE PAGE 709 FOR ADDITIONAL PICTURES]

Special Group Teaching Programs

DEMONSTRATIONS

DAILY FROM 9:00–10:00 A.M.
(All in or near the Exhibit Hall)

1. OBSTETRICS AND GYNECOLOGY—Stage of Exhibit Hall

MONDAY, OCT. 6: **Toxemias of Pregnancy**
Movie and discussion. Discussion leader: Harold W. Shutter, M. D., Milwaukee

TUESDAY, OCT. 7: **Breech Extraction with Forceps to After-Coming Head**
Movie and discussion. Discussion leader: F. J. Hofmeister, M. D., Milwaukee
(Manikin Demonstration as Part of Program)

WEDNESDAY, OCT. 8: **Antidote to Fetal Depression Induced by Obstetric Analgesics**
Movie and discussion. Discussion leaders: Wm. V. Luetke, M. D., Madison, and O. Sidney Orth, M. D., Madison

2. FRACTURES AND APPLICATION OF CASTS—Stage of Exhibit Hall

Emphasis will be placed on fractures of the radius, lower end, and fractures of the ankle. Fractures of the shaft of the humerus will also be included. Demonstrations by members of the Wisconsin Orthopedic Society, under the direction of Joseph R. Stone, M. D., Milwaukee, and James Nellen, M. D., Green Bay

3. X-RAY INTERPRETATIONS—Dressing Room East of Stage

MONDAY, OCT. 6: **Scout Film of the Abdomen:** Robert W. Byrne, M. D., Milwaukee

TUESDAY, OCT. 7: **X-Ray Diagnosis of Fractures:** Hobart Wright, M. D., Milwaukee

WEDNESDAY, OCT. 8: **Common Lesions of the Skull as Revealed by X-Ray:** Lester W. Paul, M. D., Madison

(Those attending any of these x-ray conferences are invited to bring with them interesting and significant x-rays for discussion)

4. ANESTHESIA DEMONSTRATION ON RESPIRATION—Foot of Stage

Each day members of the Wisconsin Society of Anesthesiology will conduct demonstrations, with the use of live patients, on the newest methods of manual artificial respiration. Robert R. Brazy, M. D., Veterans Hospital, Wood, will serve as lecturer during the course of the demonstrations. In addition, the use of the anesthetic machine and a simple oxygen tank, bag, and mask, as well as special instruments used in resuscitation by the anesthesiologist will be featured as part of the demonstration.

(THIS WILL BE REPEATED ON MONDAY AND TUESDAY AFTERNOON, DURING THE RECESS PERIOD, IN ADDITION TO THE DAILY MORNING DEMONSTRATIONS)

Related Demonstrations

ANATOMY: The Anatomy Department at the University of Wisconsin will conduct demonstrations on "The Anatomy of the Abdominal Cavity" each day of the Annual Meeting. Drs. O. V. Hibma and O. A. Mortensen will be in charge of the demonstrations.

GROSS TISSUE: The Wisconsin Society of Pathologists will again present interesting displays and discussions on pathologic material of special significance.

HEARING: In booth 18 the Maico company will have on display special equipment being used for the detection of deafness in very young children, malingerers, and the suspected psychogenically deafened patient.

STATE MEDICAL SOCIETY of WISCONSIN
Annual Meeting

ROUND TABLE RESERVATIONS

Hotel Schroeder - Milwaukee - October 6-7-8, 1952

Important...

IF YOU HAVE NOT ALREADY MADE YOUR RESERVATIONS FOR LUNCHEONS AND DINNER, DO SO *IMMEDIATELY*.

ATTENDANCE IS LIMITED, SO FOR ALL ROUND TABLES *PLEASE GIVE ALTERNATE SELECTIONS*. OTHERWISE DELAY IN CORRESPONDENCE WILL REDUCE YOUR CHANCES FOR PARTICIPATION IN LUNCHEONS OF YOUR SECOND AND THIRD CHOICES.

USE THE RESERVATION BLANK PROVIDED, AND MAIL TODAY.

NOTE THESE SPECIAL LUNCHEONS FOR SPECIAL GROUPS:

Monday: Past Presidents of the State Society
Tuesday: CAA Medical Examiners
Pathologists
Wednesday: Ophthalmology and Otolaryngology (with Section Meeting)

ADDITIONAL OUT-OF-STATE SPEAKERS

JOHN A. ANDERSON, M.D.
Prof. and Head of Dept. of Pediatrics, Stanford Univ., San Francisco

D. N. DANFORTH, M.D.
Asst. Prof. of Ob. and Gyn., Northwestern Univ. Medical School, Evanston, Illinois

SPRAGUE H. GARDINER, M.D.
Asst. Prof. of Ob. and Gyn., Indiana Univ. School of Med., Indianapolis

JOHN A. ANDERSON, M.D.

REYNOLD A. JENSEN, M.D.
Asst. Prof. of Pediatrics, Univ. of Minnesota Medical School, Minneapolis

HAYES MARTIN, M.D.
Asst. Prof. of Clinical Surgery, Cornell Univ. Medical College, New York City

E. T. McENERY, M.D.
Asst. Clin. Prof. of Pediatrics, Loyola Univ. School of Medicine, Chicago

1952 Annual Meeting Round Tables

MONDAY, OCTOBER 6

FOURTH FLOOR LOCATIONS:

1. Parlor A: **Resuscitation of Patients Who Die in the Operating Room:** Claude Beck, M. D., Cleveland (Warner Bump, M. D., Rhinelander, Chairman)

2. Parlor B: **Some Aspect of Portal Hypertension:** Jacob K. Berman, M. D., Indianapolis (E. R. Schmidt, M. D., Madison, Chairman)

3. Parlor C: **Newer Drugs and Their Uses:** W. S. Middleton, M. D., Madison

4. Parlor D: **Anticoagulate Therapy: Present Status and Recent Advances:** F. W. Madison, M. D., Milwaukee

5. Parlor E: **Application of Newer Drugs in the Treatment of Hematologic Disorders:** Tibor Greenwalt, M. D., Milwaukee

6. Parlor F: **Making Hospitalization Serve Its Purpose:** Leslie Osborn, M. D., Madison

7. Parlor H: **Industrial Eye Injuries:** John Hitz, M. D., Milwaukee

8. Parlor I: **Surgical Treatment of Prostatic Hypertrophy:** J. B. Wear, M. D., Madison

FIFTH FLOOR LOCATIONS:

9. Room 507: **Selection and Training of Interns and Residents:** John Hirschboeck, M. D., Milwaukee

10. Room 508: **Diagnostic Criteria and the Surgical Results of Mitral Stenosis:** Forester Raine, M. D., Milwaukee, and Nathan Grossman, M. D., Milwaukee

11. Pine Room: **General Prognostic Considerations of Psychotic and Neurotic Patients:** Annette C. Washburne, M. D., Madison

SPECIAL LUNCHEONS

12. East Room (Fifth Floor, immediately opposite Crystal Ballroom): **Legal Aspects of Medical Practice:** Chester C. Schneider, M. D., and Mr. Kenneth Grubb, Milwaukee. NOTE: Attendance at this will not be restricted, but advance reservations for the luncheon are required.

13. Parlor G (Fourth Floor): PAST PRESIDENT'S LUNCHEON: Open to past presidents and the incoming president of the State Society.

TUESDAY, OCTOBER 7

FOURTH FLOOR LOCATIONS:

1. Parlor A: **Infectious Diseases with Particular Reference to Brucellosis:** Wendall Hall, M. D., Minneapolis (John Brown, M. D., Madison, Chairman)

2. Parlor B: **Disturbances of Menstruation:** Allan Barnes, M. D., Columbus, Ohio (William Hovis, M. D., Milwaukee, Chairman)

3. Parlor C: **Diabetes Mellitus:** Bruno Peters, M. D., and William Engstrom, M. D., Milwaukee

4. Parlor D: **Choice Among the Antibiotics:** Harry Beckman, M. D., Milwaukee

5. Parlor E: **Obstetrical Anesthesia:** Sprague Gardiner, M. D., Indianapolis (L. T. Servis, M. D., Milwaukee, Chairman)

6. Parlor F: **Diagnostic and Therapeutic Application of Radioactive Iodine:** E. C. Albright, M. D., Madison

7. Parlor G: **Management of Peripheral Arterial Diseases:** James E. Conley, M. D., Milwaukee

8. Parlor H: **Management of Alcoholism:** Fritz Kant, M. D., Madison

FIFTH FLOOR LOCATIONS:

9. Room 507: CAA MEDICAL EXAMINERS: A. J. Herbolsheimer, M. D., Chicago (S. E. Gavin, M. D., Fond du Lac, Chairman)
(As part of program O. H. Comess, M. D., Chicago, will discuss "Air Transportation of Persons")

10. Room 508: **Better Business Practices in Doctors' Offices:** Mr. J. P. Revenaugh, Professional Business Management, Chicago (R. S. Baldwin, M. D., Marshfield, Chairman)

11. Pine Room: **Problems of the Newborn:** E. T. McEnery, M. D., Chicago (J. P. Conway, M. D., Milwaukee, Chairman)

12. Pere Marquette: "**Electrolyte Metabolism:** Paul R. Cannon, M. D., Chicago
(This luncheon will be open to everyone up to 40 persons. Following the luncheon and discussion there will be a regular meeting of the Wisconsin Society of Pathologists)

SPECIAL LUNCHEON

13. Convalescent Home: SPECIAL LUNCHEON AND CLINICAL DISCUSSION ON "RHEUMATIC HEART DISEASE" (Limit 25): Ely Epstein, M. D., Chairman

[USE RESERVATION SLIP ON PAGE 711]

WEDNESDAY, OCTOBER 8

)URTH FLOOR LOCATIONS:

Parlor A: **The Choice of Medical vs. Surgical Therapy in Massive Upper Gastrointestinal Hemorrhage:** Robert Elman, M. D., St. Louis, Missouri (Joseph Gale, M. D., Madison, Chairman)

Parlor B: **Cancer of the Head and Neck:** Hayes Martin, M. D., New York (E. R. Schmidt, M. D., Madison, Chairman)

Parlor C: **Treatment of Vaginal Discharge:** Benjamin E. Urdan, M. D., Milwaukee

Parlor D: **Nephrosis in Children:** John Anderson, M. D., San Francisco (John Gonce, M. D., Madison, Chairman)

Parlor E: **Newer Drugs and Their Uses:** O. O. Meyer, M. D., Madison

Parlor G: **Recent Advances in Hormonal Therapy in Cancer:** A. R. Curreri, M. D., Madison

Parlor F: **Metabolic Problems in General Practice:** E. S. Gordon, M. D., Madison

Parlor H: **Indications and Limitations of ACTH, Cortisone, and the Antihistamine Drugs in Dermatologic Treatment:** Harry Foerster, M. D., Milwaukee

Parlor I: **The Treatment of Head Injuries:** David Cleveland, M. D., Milwaukee

FTH FLOOR LOCATIONS:

Room 507: **"Anxieties" as Seen in the Practice of Medicine:** Elwood Mason, M. D., Milwaukee

Room 508: **The Child Who Fails in School:** Reynold A. Jensen, M. D., Minneapolis (H. Kent Tenney, M. D., Madison, Chairman)

Committee Room: **Problems of Hypertension:** Charles Crumpton, M. D., Madison

Pine Room: **The Treatment of Bronchial Asthma:** Howard Lee, M. D., Milwaukee

Pere Marquette: **Roentgen Diagnosis of Benign Gastric Ulcers:** Harold Peterson, M. D., Minneapolis (S. A. Morton, M. D., Milwaukee, Chairman)

SPECIAL LUNCHEON AND SECTION MEETING

East Room (Fifth Floor, Hotel Schroeder): LUNCHEON FOR SECTION ON OPHTHALMOLOGY AND OTOLARYNGOLOGY: George Nadeau, M. D., Green Bay, Acting Chairman

12:15 p. m.: Luncheon

1:00 p. m.: Business Meeting and Election of Officers

1:30 p. m.: **Some New Points in Cochlear Anatomy and Physiologic Implications:** Arthur C. Hilding, M. D., Duluth, Minnesota

2:00 p. m.: **The Present Status of Orthoptics in Ophthalmology:** John Hitz, M. D., Milwaukee

2:20 p. m.: **Newer Methods of Detecting Hearing Loss:** Charles R. Taborsky, M. D., Madison

2:40 p. m.: **Treatment of Shallow Angle Glaucoma:** Joseph S. Haas, M. D., Chicago

ROUND TABLE AND DINNER RESERVATION

FILL OUT AND MAIL WITH YOUR CHECK TO STATE MEDICAL SOCIETY OF WISCONSIN, BOX 1109, MADISON

ATTENDANCE LIMITED, SO LIST ALTERNATE CHOICES OF LUNCHEONS ON DAYS YOU WILL ATTEND . . . DINNER LIMIT IS 500

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I Wish to Attend One of These Luncheons in the Order Given

MONDAY, OCTOBER 6:

	Number of Luncheon	Leader
1st Choice	_____	_____
2nd Choice	_____	_____
3rd Choice	_____	_____

TUESDAY, OCTOBER 7:

	Number of Luncheon	Leader
1st Choice	_____	_____
2nd Choice	_____	_____
3rd Choice	_____	_____

WEDNESDAY, OCTOBER 8:

	Number of Luncheon	Leader
1st Choice	_____	_____
2nd Choice	_____	_____
3rd Choice	_____	_____

[Make Check Payable to "State Medical Society of Wisconsin"]

ANNUAL DINNER, TUESDAY, OCTOBER 7

Number of reservations ($4.50 per plate) _____

Signed _____
(Print Please)

Address _____

City _____

Hospital Staff Conferences

MONDAY—Oct. 6—Milwaukee Auditorium

All conferences will feature actual patients for demonstration purposes, whenever possible. These teaching conferences have become a popular feature of the Annual Meeting, and your participation through attendance is invited.

1. PEDIATRIC CONFERENCE: Staff of Children's Hospital, Milwaukee

WALKER HALL, MILWAUKEE AUDITORIUM: James P. Conway, M. D., Milwaukee, Moderator

Arthritis in Children: Vernon Kores, M. D.
Nephrosis: W. S. Polacheck, M. D.
Encephalitis: P. S. Pierson, M. D.

2. DISEASES OF THE PANCREAS: Staff of Veterans' Hospital, Wood

(Excluding diabetes mellitus, per se)

NORTH JUNEAU HALL, MILWAUKEE AUDITORIUM: Maurice Hardgrove, M. D., Milwaukee, Moderator

Physiology of the Pancreas and Laboratory Aids of Value in Diagnosis of Pancreatic Diseases: Joseph M. Lubitz, M. D.

Roentgenologic Aspects of Pancreatic Disorders: Theodore J. Pfeffer, M. D.

Acute and Chronic Pancreatitis:

Medical Aspects: Bruno J. Peters, M. D.

Surgical Aspects: C. M. Schroeder, M. D.

Tumors of the Pancreas: Forrester Raine, M. D.

3. SURGICAL–MEDICAL CONFERENCE: Staff of Milwaukee County Hospital

SOUTH KILBOURN HALL, MILWAUKEE AUDITORIUM: Joseph King, M. D., Milwaukee, Moderator

The Immediate Care of Injuries of the Hand: Frederick Bunkfeldt, M. D.

Pyelitis of Pregnancy: George S. Kilkenny, M. D.

The Treatment of Congestive Heart Failure: J. Kenneth Karr, M. D.

Late Complications of a Gunshot Wound: Joseph J. Gramling, M. D.

Carcinoma of the Lung: Joseph W. Rastetter, M. D.

X-Ray Diagnosis of Intra-abdominal Calcifications: Jerome L. Marks, M. D.

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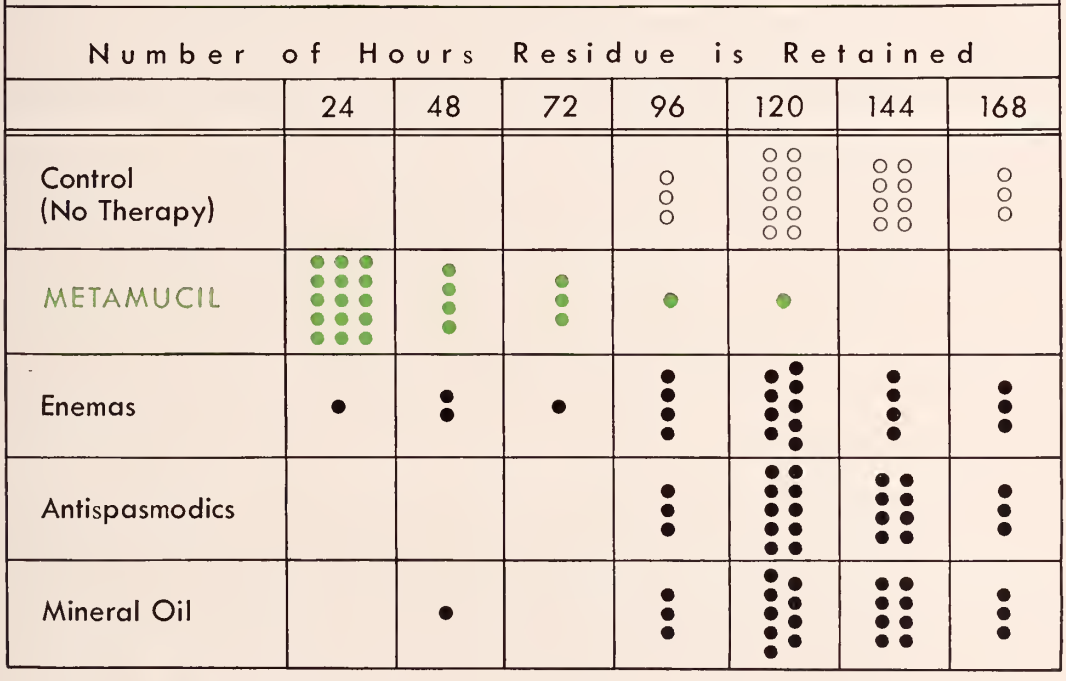
Effective in Distal Colon Stasis*

"A roentgenographic evaluation of the common methods of therapy . . . demonstrated that . . . a mucilloid substance (Metamucil) has been most effective in the most prevalent [type of colonic stasis], distal colon stasis. . . . Enemas gave good results in rectal stasis only. Mineral oil had very little effect. Antispasmodics and sedatives had no efficacy. . . . It was found that the use of habit forming cathartics may be avoided in most instances."*

Comparative Response to Common Methods of Therapy in Distal Colon Stasis*



METAMUCIL® is the highly refined mucilloid of Plantago ovata (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent.

*Barowsky, H.: A Roentgenographic Evaluation of the Common Measures Employed in the Treatment of Colonic Stasis, Scientific Exhibit, National Gastroenterological Association, Chicago, Sept. 17-22, 1951.

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COMMITTEE *Concentrates*

Because of the AMA meeting being held in Chicago in June, a relatively small number of committee meetings were held, but what meetings were held developed projects of considerable importance to the entire profession.

CONFERENCE COMMITTEE ON OPEN PANELS
Sub-Committee of Council on Medical Services

JUNE 4

MDs Present: David Goldstein and D. M. Willison (as well as the two insurance representatives and Mr. Harry Nelson, director of the Workmen's Compensation Division, State Industrial Commission)

Reviewed simplified report forms and agreed to incorporate charts covering foot and hand injuries, so reporting of loss of fingers and toes can be simplified for the doctor . . . . Discussed a complaint of the Industrial Commission on a specific case treated by a participating physician and scheduled a hearing for July.

COMMISSION ON PREPAID PLANS

JUNE 14–15

MDs Present: E. M. Dessloch, Robert Krohn, N. A. Hill, J. T. Sprague, T. D. Elbe, H. E. Kasten, R. E. Garrison, K. H. Doege, Milton Finn, C. G. Reznichek, J. S. Supernaw, H. A. Aageson, R. M. Moore, P. B. Mason, W. C. Stewart, Richard Foregger, A. H. Heidner, R. C. Parkin.

Commission first met as sub-committees, and then as joint Commission. Highlights of sub-committee reports—*Enrollment and Underwriting:* Recommended study, with Blue Cross, of policy to cover experience in event of strikes, leaves of absence, and layoffs . . . Recommended conditions under which subscribers who cease affiliation with a group can continue their participation through a conversion contract . . . Recommended extension of the program to persons over 65 on a non-group basis, under certain conditions and with certain restrictions . . . Recommended that, where a risk affirmatively withholds portions of the WPS premiums as a device to settle contested claims, such contract will be regarded as being automatically cancelled . . . Recommended that in groups of more than 100 employees, with more than 90 per cent as subscribers, a guaranteed annual rate be determined, with equal assurance that the contract would be held in force for the same period as the guaranteed rate . . . *Research and Development:* Recommended special studies in respect to catastrophic coverage and optional schedules, such as for therapeutic and diagnostic x-ray . . . . Recommended the consideration of a research fellowship which would enable a graduate student to secure his Ph.D. by engaging in specific research matter in fields to be studied . . . Recommended study of practicability of providing a cash benefit, in addition to service benefits, to take care of special nursing services, medications, appliances, etc. Did not approve of suggestion that cash benefits be paid the subscriber, as this would not necessarily pay for the special services covered . . . . Recommended staff study of plan whereby a subscriber can pay an additional sum for continuation of benefits beyond period of employment and active participation . . . *Executive Committee:* Recommended development of indemnity contracts as available features of the program, in cases where a program of reduced premiums is desired . . . . Reviewed all reports of sub-committees and prepared combined recommendations for Commission, and ultimate report to Council and House of Delegates.

COMMITTEE ON GRIEVANCES

JUNE 25

MDs Present: R. E. Fitzgerald, F. A. Nause, E. W. Mason, C. E. Zellmer, A. H. Heidner.

As is customary, the details of these meetings are not reported, because of the confidential nature of the discussions, but the meetings are listed so the membership is apprised of the continuing activities of this important committee of the State Society.

JOINT MEETING OF INTERIM COMMITTEE, AUDIT AND BUDGET, AND HISTORICAL COMMITTEE

JUNE 21–22

MDs Present: R. G. Arveson, A. H. Heidner, E. M. Dessloch, J. C. Griffith, H. K. Tenney, N. J. Wegmann.

Primary consideration given to problems involving the housing of the expanded activities of the State Medical Society, and the proposal that the State Medical Society take over the deed and management of the Old Fort Crawford Military Hospital at Prairie du Chien . . . . Staff authorized to study alternate locations and building sites in Madison, for report to Council in July, and also suggested that the matter of the historic shrine be given more study, and consultation with specialists in the field, including the State Historical Society. Interim Committee authorized the discontinuation of the Secretaries Luncheon at the Annual Meeting and urged the development of special conferences for presidents and secretaries at times other than in connection with the Annual Meeting.

COORDINATING COMMITTEE ON POSTGRADUATE EDUCATION

JUNE 26

MDs Present: G. E. Collentine, Jr., Robert C. Parkin, Joseph Gale, E. H. Jorris, R. P. Welbourne, Donald Ausman.

Purpose of the meeting to review the experience in postgraduate teaching in 1951–52 and to plan circuit teaching programs for the next academic year . . . Plans are to hold monthly circuits from December through June, omitting all hospital meetings as a part of the program. Report showed that with support of State Board of Health and the various affiliate agencies the entire program was self-supporting in so far as withdrawals from the SMS dues account was concerned.

RELATED ACTIVITIES IN JUNE

Press conferences held in Wausau, June 5, La Crosse, June 19, and Superior, June 26. All well attended, and productive of good public relations. Summary of all meetings and conclusions being prepared by Mr. Thayer, director of public information . . . Final postgrad clinic held at resort near Siren on June 18. Huge turnout of wives and doctors made meeting unqualified success. Speakers were Drs. John Hirschboeck and George Kilkenny, Marquette, and O. O. Meyer and H. K. Tenney, U. of W. . . . well over 400 members took part in all teaching programs this year, which represents over 15 per cent of active membership.

AMERICAN CONGRESS OF PHYSICAL MEDICINE ANNOUNCES ANNUAL MEETING

The thirtieth annual scientific and clinical session of the American Congress of Physical Medicine will be held on August 25, 26, 27, 28 and 29, 1952 inclusive, at The Roosevelt Hotel, New York, N. Y. Scientific and clinical sessions will be given on the days of August 25, 26, 27, 28 and 29.

All sessions will be open to members of the medical profession in good standing with the American Medical Association.

In addition to the scientific sessions, annual instruction seminars will be held. These lectures will be open to physicians as well as to therapists, who are registered with the American Registry of Physical Therapists or the American Occupational Therapy Association. Full information may be obtained by writing to the American Congress of Physical Medicine, 30 North Michigan Avenue, Chicago 2, Illinois.

. . . . THE PRESIDENT'S PAGE . . . .

Improving First Impressions

THE major effort of the State Medical Society this year to develop a better understanding between the public and the medical profession has so far been directed toward meetings with large groups. This will be continued by a meeting of doctors and Wisconsin educators at Madison next October.

All of this is important and I believe is producing satisfactory results.

As one studies this subject carefully, however, he is impressed by the fact that the most crucial point in which good or bad relations are made with the public is in the individual physician's office.

The patients we treat, and from whom we derive our livelihood, are not particularly interested in how doctors get along with lawyers, dentists, pharmacists, or educators. What they want is good medical service when they need it. They want to feel that their doctor is their friend, personally interested in their welfare, and willing and anxious to help them when they are in trouble.

Medical treatment has changed a great deal in recent years. It has become to a large extent less personal and more mechanical. Physicians have found that their office personnel can perform many mechanical details leaving more time for professional attention to medical problems. This may lead to an atmosphere of efficiency rather than friendliness and cordiality. However, if the office personnel consists of people with friendly dispositions, this feeling of austereness will disappear.

In eight out of ten cases a woman's voice answers the phone and is the first contact made when a call comes into a doctor's office or home. The impression made by this voice is one of the most important factors in establishing harmony or disharmony in a physician's practice.

A sympathetic response when the person calling is anxious or excited, or a cheerful and courteous voice when it is impossible to get in contact with the physician immediately will be the deciding factor in relieving tension and disappointment.

The multiplicity of the duties of the physician's office secretary makes it difficult for her to secure training in any one place. In other words, much of the instruction she receives must come from the doctor himself.

Much of her time is spent in filling out insurance and government forms, public health notices, office records, tax data and other paper work. She is constantly interrupted by telephone calls and must act as a buffer between an excited and often unreasonable patient, and an over-worked and sometimes irritable boss. That she keeps as calm and courteous as she usually does reflects greatly to her credit.

To make her work easier, simpler, and more understandable is the latest venture of your State Medical Society.

We are planning a series of courses for doctors' office personnel to be held in various parts of the state. One trial meeting has already been held for 18 doctor's employees with unusual success. More are to be scheduled. With the experience gained through these meetings, a state wide plan will be developed.

If anyone has any suggestions send them in.

We believe that with the full cooperation of our doctors this plan may well become one of the most valuable and practical projects our State Society has yet developed.

Albin T. Heidner M.D.

"...particularly beneficial in the treatment of hay fever."[1]

Because CHLOR-*TRIMETON*® maleate, chlorprophenpyridamine maleate, has the greatest potency milligram for milligram of any available antihistamine, and because "Chlor-Trimeton has a relatively low incidence of side reactions,"[2] it is a drug of choice for hay fever patients.

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1. Silbert, N. E.: New England J. Med. *242*:931, 1950.
2. Eisenstadt, W. S.: Journal Lancet *70*:26. 1950.

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Facts about

Blue Shield of Wisconsin

an agency of the State Medical Society of Wisconsin

Prepared by the Commission on Prepaid Plans of the State Medical Society of Wisconsin, E. M. Dessloch, Prairie du Chien, Chairman.

Payment for Medical Care and Minor Surgery on the Same Day

The State Medical Society's Commission on Prepaid Plans has established a policy that permits payment of Wisconsin Physicians Service benefits for minor surgical services concurrently with medical services in the hospital.

> EXAMPLE: Patient is hospitalized for chronic lymphatic leukemia with severe anemia. This is strictly a medical care case. However, during the 12-day hospital stay, six blood transfusions were given on six different days. Question is whether Wisconsin Physicians Service will pay a medical care benefit on the same day it pays a minor surgical (blood transfusion) benefit.

The Commission of physicians ruled that concurrent payment is to be made in these circumstances, and therefore authorized payment for eight days of medical care—a total of $24 under the "old" WPS contract—and six blood transfusions—$10 for the first and $5 for each transfusion thereafter under the "old" contract.

* * *

Benefit for Removal of Hardware

Cases requiring the removal of hardware used in fracture treatment may receive a benefit of approximately 25 per cent of the original surgical benefit. This is a recent decision of the Commission on Prepaid Plans of the State Medical Society. Heretofore, this procedure has been considered part of usual postoperative care, even though it may have necessitated separate surgical procedures many months after the original fracture treatment.

* * *

Fees for Arteriograms

The following fees for arteriograms have been established by the Commission on Prepaid Plans on the basis of type of procedure:

(1) Percutaneous puncture through the skin—$50 whether on one or both sides, for persons covered by the "old" WPS contract.

(2) Neck dissection to the carotid—$75 whether one or both sides, for persons covered by the "old" WPS contract.

Fees for these procedures under the new "A" and "B" contracts have not yet been established by the Commission.

* * *

Needle Surgery Treatment of Hernia

Benefits for the needle surgical treatment of hernia have been established by the Commission on Prepaid Plans. The Commission recognizes the treatment as a procedure covered by Wisconsin Physicians Service and indicates that a maximum of 15 treatments at $3 each would be allowable under the "old" WPS contract.

* * *

Fees for Adrenalectomy

The following fees have been established for adrenalectomy:

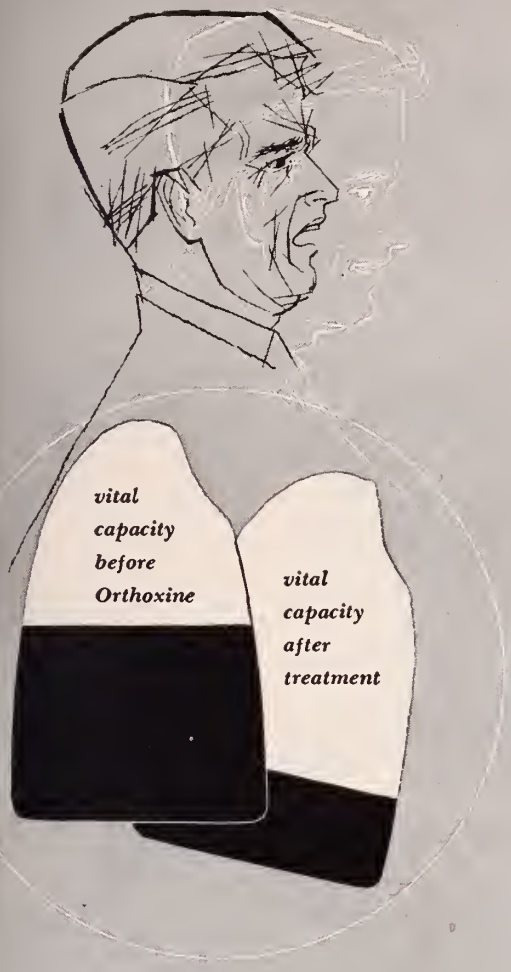
"Old" WPS Contract	$150
"B" WPS Contract	$200
"A" WPS Contract	$300

* * *

Tips on Reporting

The following suggestions will make your reports more complete:

1. Give a detailed description of the services rendered. For example, indicate the number of sutures made in closing a wound, and the location of that wound on the body.
2. Indicate whether fractures or dislocations required no reduction, open reduction or closed reduction.
3. Show whether a hysterectomy was total or sub-total, abdominal or vaginal.
4. In cases of mastectomy, report whether the procedure was simple or radical.
5. In certain procedures, it is important to know whether services were unilateral or bilateral. Please indicate which was done.
6. Correctly record the dates on which surgery was performed.
7. If you were the attending physician but did not do the surgery, please include the name of the surgeon.
8. If you did the surgery, but were not the attending physician, please report the name of the attending physician.



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A. Orthoxine Hydrochloride provides bronchodilatation with minimal vasopressor and psychomotor stimulation. By modifying the configuration of a sympathomimetic amine molecule, the action of Orthoxine has been centered mainly upon bronchodilatation, thereby minimizing side-effects arising from vasopressor or psychomotor-stimulating activity.

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BRAND OF METHOXYPHENAMINE

Bottles of 100 and 500 tablets.

Orthoxine Hydrochloride (100 mg.) tablets contain *beta-(ortho-*methoxyphenyl)-isopropyl-methylamine hydrochloride, a bronchodilator and antispasmodic.

For Adults: ½ to 1 tablet (50 to 100 mg.)

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Society Proceedings

Douglas

Dr. John F. Schmid, a dermatologist from Duluth, Minn., was the speaker at the June 4 meeting of the Douglas County Medical Society held in Superior. His talk was entitled "Eruptive Bullous Lesions of the Skin" and was illustrated with colored slides. During the business meeting *Dr. J. J. McLeod, Jr.*, who is now serving in the Japanese–Korean Theatre, was accepted as a War Member.

Fond du Lac

Members of the Fond du Lac County Medical Society met in Green Lake at Norten's on May 22 to hear an address by Dr. Clark Kuebler, president of Ripon College. Following dinner, Doctor Kuebler spoke on "Responsibilities of the Medical Profession in Present Day Problems." The only business conducted was the acceptance into membership of *Dr. H. R. Sharpe, Jr.*

Pierce–St. Croix

"Carcinoma Prostate" was the subject of an address by Dr. B. J. McGroarty of St. Paul, Minn., when he spoke before the Pierce–St. Croix County Medical Society. The Society held its meeting on this occasion at The Terrace in Somerset. During the business meeting, malpractice insurance and immunization were discussed. On the latter, action was delayed until the next meeting.

Price–Taylor

Dr. J. L. Murphy, Park Falls, was elected president of the Price–Taylor County Medical Society at the May 24 meeting in Park Falls at the Leahy Clinic. Other officers elected are as follows: *W. W. Meyer*, Medford, vice-president; and *J. L. Leahy*, Park Falls, secretary.

The guest speaker was *Dr. G. E. Collentine, Jr.*, coordinator of postgraduate education at Marquette University School of Medicine. The doctor's subject was "Venous Thrombosis."

Waupaca

E. J. ZEISS

When the Waupaca County Medical Society met in Clintonville on March 15, the following officers were elected for this year: *Drs. L. G. Patterson*, Waupaca, president; and *Robert Bolinske*, Clintonville, secretary-treasurer. *Dr. Edward J. Zeiss* of Appleton was the speaker during the scientific session. His subject was "Eye Injuries."

International College of Surgeons Wisconsin Chapter

The Monroe Clinic, Monroe, and the St. Clare Hospital were hosts to the spring meeting of the Wisconsin Chapter of the International College of Surgeons on May 15. The morning and afternoon sessions, held at the hospital, included an operative clinic and special papers by the following Monroe physicians: *W. J. Fencil, W. B. Gnagi, Jr., K. B. Witte, N. E. Bear, J. A. Schindler, E. E. Eckstam, B. J. Brunkow*, and *E. E. Peters.*

A banquet was held in the evening at the Monroe Country Club, at which time Doctor Schindler discussed the interrelation of the surgeon and the diagnostician.

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Medical Director

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what is "therapeutic bile"?

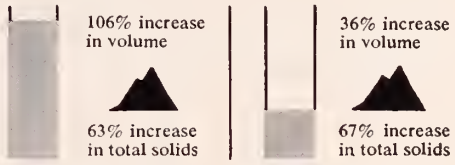
Thin, free-flowing bile in copious amounts as produced by *hydro*choleresis with *Decholin.*

what does "therapeutic bile" do?

Overcomes stasis in chronic cholecystitis and noncalculous cholangitis by flushing thickened bile, mucus plugs and debris from the biliary tract.

how does "therapeutic bile" differ from other bile?

"THERAPEUTIC BILE" is higher in fluid content and lower in solid content than bile produced by choleretics, e.g., ox bile salts.



*Hydro*choleretic: *Decholin*

Choleretic: Ox bile salts

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how is "therapeutic bile" obtained?

"THERAPEUTIC BILE" is obtained by adequate dosage of *Decholin* and *Decholin Sodium.* Most patients require one or two tablets t.i.d. for four to six weeks. Prescription of 100 tablets is recommended for maximum efficacy and economy. More prompt and intensive *hydro*choleresis may be achieved by initiating therapy with *Decholin Sodium* 5 cc. to 10 cc. intravenously, once daily.

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News Items and Personals

Mellen Honors Doctor Lockhart

Dr. Carl W. Lockhart, Mellen physician for the past 51 years, was named "Outstanding Citizen of the Year" by the Lions Club of Mellen. Doctor Lockhart is the first to be given this honor. The program included dinner and a number of speakers who told of the activities of the doctor during the past 51 years. *Dr. C. J. Smiles*, Ashland, gave a talk for the medical profession of the area, complimenting Doctor Lockhart for his good work over such a long period.

Doctor Heidner Addresses West Bend Audience

Dr. A. H. Heidner, president of the State Medical Society, was the principal speaker at a recent meeting of the West Bend Chapter of the American Red Cross. The meeting was called in the interest of the coming of the Blood Bank Clinic, during which time the Red Cross and the Community Blood Donor Club were seeking 1,000 volunteers to donate a pint of blood. The subject of Doctor Heidner's address was "Blood—The Medicine We Make Ourselves."

Northwoods Residents Fete Woman Doctor

More than 20 years of service to northwoods residents in Oneida and Vilas counties as a country physician was recognized on May 8 when *Dr. Kate Pelham Newcomb* was honored by the Arbor Vitae–Woodruff Lions Club at a testimonial dinner. At this meeting she was awarded a plaque for community service. A graduate of the University of Buffalo School of Medicine, Doctor Newcomb and her family moved to Wisconsin in 1926, and she started practicing in the state in 1931.

Among the members of the medical profession who attended the dinner and who paid tribute to Doctor Newcomb were *Drs. G. R. Thuerer*, Rhinelander, president of the Oneida–Vilas County Medical Society; *C. A. Richards*, Rhinelander; *G. W. Huber*, Minocqua; and *Frances A. Cline*, Rhinelander, district health officer.

Sturgeon Bay Has New Physician

In the early part of April, Dr. Howard R. Peters of Des Plaines, Ill., opened an office to practice general medicine and surgery at Sturgeon Bay. A 1946 graduate of the University of Illinois College of Medicine, the doctor served in the U. S. Air Force for two years as a flight surgeon. Since his discharge, he had practiced in the Des Plaines area for three years.

General Practitioners Award Prize

At the last meeting of the Wisconsin Chapter of the American Academy of General Practice it was voted to establish a "Dr. Urban Schlueter Memorial Essay Contest" which would be open to seniors of Marquette and the University of Wisconsin medical schools. The prize was to be $100 to the student winner in each school.

This year's essay, "Why I Want To Be a General Practitioner," was won by Carl J. Doria of Milwaukee, who will intern at San Joaquin General Hospital, French Camp, Calif. There were no entries from the University of Wisconsin.

The prize was presented to the winner at the graduating exercises on June 10 by *Dr. E. C. Cary*, president of the Wisconsin chapter of the Academy.

Doctor Tyvand Attends 50 Year Reunion

On June 11, the University of Illinois College of Medicine held a 50 year reunion for the class of 1902. *Dr. J. C. Tyvand* of Whitehall was among the graduates present celebrating the occasion. The doctor first began practice in Wisconsin at Barneveld in 1912 and moved his office to Whitehall in 1916.

Ft. Atkinson Honors Physician and Nurse

The residents of Ft. Atkinson honored *Dr. H. O. Caswell*, Jefferson, and Mrs. Johanna Clark, Ft. Atkinson city and school nurse, at a recent community party. Doctor Caswell had practiced in Ft. Atkinson for over half a century before retiring about four years ago. He later came out of retirement and is now resident physician at the Forest Lawn Sanatorium at Jefferson. Mrs. Caswell, who has served the city since 1923, is retiring as school nurse but will continue as city nurse.

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General Surgery, Two Weeks, starting October 6
General Surgery, One Week, starting October 6
Breast & Thyroid Surgery, One Week, starting October 6
Esophageal Surgery, One Week, starting October 13
Thoracic Surgery, One Week, starting October 20
Fractures & Traumatic Surgery, Two Weeks, starting October 6

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THIRD AND TWELFTH DISTRICT NEWS

Doctor Harris Addresses Iowa Group

J. W. HARRIS

Dr. J. W. Harris, professor of obstetrics and gynecology at the University of Wisconsin, was a guest speaker at the annual meeting of the Iowa State Medical Association which was held in Des Moines. The subjects of Doctor Harris's talks were "Prenatal Care — Accomplishments and Failures" and "The Choice of Operative Procedures in the Management of Uterine Prolapse." Doctor Harris also recently attended the annual meeting of the American Gynecological Society in Hot Springs, Va.

Doctor Curreri to Tour Korean Hospitals

Dr. A. W. Curreri left Madison on June 9 for a six weeks tour of Korea as a consultant to the U. S. Surgeon General. The doctor, an associate professor of surgery at the University of Wisconsin, will visit hospitals and aid stations and study methods of treatment of fighting men suffering from shock as a result of battle wounds. The trip is part of the general program of the Surgeon General's office to improve medical treatment of American soldiers through consultations with civilian medical experts.

Doctor Benson Transferred to Madison VA Hospital

The appointment of Dr. G. B. Benson, formerly of Richland Center, as chief of the physical medicine rehabilitation division of the Madison Veterans Administration Hospital was announced recently by Dr. Morris C. Thomas, hospital manager. A graduate of the University of Wisconsin and Rush Medical Center, Chicago, Doctor Benson had been located at the VA Hospital in Downey, Ill. Prior to entering government service, he had practiced in Richland Center with his father, the late Dr. Gideon Benson.

Papers Presented by Madison Surgeon

Dr. T. C. Erickson, associate professor of surgery at the University of Wisconsin, attended the annual meeting of the American Neurological Association held at Atlantic City, N. J., May 8–10. At this meeting he presented two papers—the first entitled "Observations of the Post Central Gyrus in Relation to Pain" was prepared in collaboration with *Dr.*

W. J. Bleckwenn and Dr. C. N. Woolsey, and the second entitled "Late Meningeal Reaction to Pantopaque Used in Myelography" was prepared in collaboration with Dr. H. J. Van Baaren.

The gentleman in the derby is Dean William S. Middleton of the University of Wisconsin Medical School. The occasion was Derby Day, celebrated in February by juniors at the University of Wisconsin continuing a 39-year tradition at the University. The angel at the left is E. S. Sullivan, Jr., Madison. The devil is H. J. Watson, Jr., Milwaukee. In the background is J. R. Fitzsimmons, Madison, about to test Dean Middleton's reflexes. Derby Day, an unscheduled occasion each year, provides the medical students with an opportunity to josh their professors.*

Doctor Conway Accepts Shorewood Post

Dr. James P. Conway, assistant clinical professor at Marquette University School of Medicine, was recently appointed village health commissioner by the Shorewood Board of Health. On May 24, the doctor was elected president of the American Association of Medical Milk Commissions, succeeding *Dr. J. Gurney Taylor* of Milwaukee.

American Academy of General Practice Milwaukee Chapter

The May 20 meeting of the Milwaukee Chapter, American Academy of General Practice was held at the Pfister Hotel. The guest speaker was Dr. Leo C. Larkin, clinical instructor in the department of surgery at Stritch School of Medicine, Loyola University, and clinical instructor in the department of proctology, Cook County Graduate School of Medicine. His subject was "Diseases Common to the Rectum."

Milwaukee Neuro-Psychiatric Society

At the annual meeting of the Milwaukee Neuro-Psychiatric Society officers for the coming year were elected. *Dr. Owen C. Clark,* Oconomowoc, will serve as president and *Dr. Walter Urben,* Mendota, as vice-president; *Dr. Francis Millen,* Milwaukee, will fill the post of secretary–treasurer. Two councilors were elected as follows: *Drs. J. A. Kindwall,* Wauwatosa, and *Harry Tabachnick,* Milwaukee.

*From the *Wisconsin Alumnus,* March 1952.

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Milwaukee Oto-Ophthalmic Society

Dr. B. P. Churchill, retiring president of the Milwaukee Oto-Ophthalmic Society was host at the May 29 meeting of the Society. This meeting, which was the annual social gathering, was held at the Town Club. There was no scientific program and only a very short business meeting.

SOCIETY RECORDS

New Members

J. F. McDonald, Sacred Heart Sanatorium, Milwaukee.

A. D. Hoff, 1417 University Avenue, Madison.

J. J. LaBreche, Stanley.

D. H. Engels, 11 South Main Street, Fond du Lac.

K. D. Epperson, St. Luke's Hospital, Chicago, Illinois.

J. J. Suits, Marshfield Clinic, Marshfield.

A. J. Gloss, 101 East Lawrence Avenue, Appleton.

G. J. Bordenave, Milwaukee County Hospital, 8700 West Wisconsin Avenue, Milwaukee.

D. D. Hassett, 2320 North Lake Drive, Milwaukee.

J. A. Palese, 1821 West Wisconsin Avenue, Milwaukee.

T. G. Allin, Jr., 113 North Carroll Street, Madison.

R. H. Brodhead, 502 Third Street, Wausau.

J. A. Larkey,* 3818 North Frederick Avenue, Milwaukee.

T. W. Dasler, 401 South Barstow Street, Eau Claire.

Changes in Address

D. A. Jeffries,* Camp McCoy, to Granite City Engineering Department, Granite City, Illinois.

H. S. Caskey,* AO 1907119 Chanute, Illinois, to 118th Medical Group, Shaw Air Force Base, Sumter, South Carolina.

J. R. Couch,* West Allis, to Lackland Air Force Base, San Antonio, Texas.

Hans Hartenstein,* San Francisco, California, to 522 East Lexington Boulevard, Milwaukee.

C. L. Junkerman,* Milwaukee, to U. S. Naval Hospital, Great Lakes, Illinois.

L. L. Larsen,* Edinburg, Texas, to C. C. B., Dispensary, Fort Hood, Texas.

W. C. Webb,* Montgomery, Alabama, to 3810th Medical Group, Maxwell Air Force Base, Alabama.

J. E. Koepsell,* Harvard, Illinois, to 501 Army Service Unit, U. S. Army Hospital, Fort Custer, Michigan.

R. G. Gage,* Little Chute, to Kimberly.

L. T. Schlenker,* Kenosha, to 6003 Army Service Unit, U. S. Army Hospital, Fort Ord, California.

N. S. Davis,* Evanston, Illinois, to Sister Bay.

F. C. Johnson, Wausau, to 1331 Drake Street, Madison.

J. E. Dettmann, Edinburg, Indiana, to 311 Northern Building, Green Bay.

E. A. Schmidt, Waupun, to Elm Grove.

R. H. Lehner, Bala-Cynwyd, Pennsylvania, to 215 William Street, Racine.

MEAT... and the Cholesterol Content of the Diet

An essential constituent of human tissue, contributing to the normal functioning of all cells, cholesterol has been widely discussed as a factor in the etiology of atherosclerosis. Yet this lipid is required in many metabolic processes, and, furthermore, evidence is lacking that withholding cholesterol from the dietary is effective in preventing atherosclerosis.

In a recent plea for a return to the basic fundamentals of nutrition in the prophylaxis of atherosclerosis, it was emphasized that to eliminate cholesterol from the diet would mean to eliminate such animal foods as meat, milk, eggs, etc.* However, nutritionists are unanimous in asserting that these protective foods contain basic essential nutrients required for good nutrition and that to deny them would be "equivalent to the negation of practically all that nutrition science has taught us in the past."

According to these authors,* elimination of animal foods from the diet to prevent the development of atherosclerosis is unjustified on the basis of present day knowledge. They state that "there certainly is no evidence that meatless, milkless, and eggless diets should be recommended as desirable to the general public."

Meat, America's favorite protein food, always has been and continues to be an important dietary source of biologically complete protein, B vitamins, and iron. Few indeed are the conditions in which its use must be interdicted.

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*Hegsted, D. M.; Mann, G. V., and Stare, F. J.: Comments on Cholesterol, Editorial, Postgrad. Med. *11*:454 (May) 1952.

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P. D. Anderson, Roanoke, Virginia, to 103 Seventeenth Place, La Crosse.

H. N. Lubing, Winnebago, to 110 East Main Street, Madison.

D. W. Kersting, Milwaukee, to 8900 Oneida Lane, Bethesda, Maryland.

D. deF. Bauer, St. Paul, Minnesota, to 178 West Commercial Avenue, Coos Bay, Oregon.

R. E. Green, Madison, to Department of Pharmacology, University of Kansas Medical Center, Kansas City, Kansas.

J. K. MacGregor, Madison, to 701 Brick and Tile Building, Mason City, Iowa.

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* Military Service Member.

DEATHS

JOSEPH SMITH

Dr. Joseph Franklin Smith, retired Wausau physician and a past president of the State Medical Society, died on March 22 in a Madison hospital. He was 82 years old.

Born July 24, 1869 on a farm near Fort Wayne, Indiana, the doctor's aim early in life was to be a physician, and at the age of 11 years he started saving money to achieve this ambition.

He went to a church school for boys, earning his way in that school through the eighth grade. After finishing this school, he entered the home of a very fine family while he worked his way through high school. He was advised to take an examination for a teachers' certificate, which he did, receiving a certificate to teach for two years. At the completion of the two years of teaching, he took a second examination receiving a teachers' life certificate. From that time forth he taught school, then went to school; taught again, went to school, until he was able to graduate from the Indiana State Teachers' College, where later he became an instructor in the departments of physics and chemistry, setting up the entire physics laboratory at that College. Later the College president encouraged Doctor Smith to continue his studies in higher institutions of learning, influencing him to enter the University of Chicago and the Rush Medical College, where Doctor Smith received his doctor of medicine degree in 1900. When Rush Medical Col-

lege became a part of the University of Chicago, he was made on alumnus of the University of Chicago School of Medicine.

While studying at the Chicago University he was given an instructorship in the physics laboratory on afternoons, attended his classes mornings, studying evenings. During this time, Röntgen developed the x-ray and Doctor Smith assisted the head of the physics department in setting up, from Röntgen's literature, the first x-ray machines at the University.

After graduating from medical school, the doctor entered the Presbyterian Hospital as an intern. During his internship he instituted the first hospital x-ray diagnostic laboratory in Chicago. He was resident house physician and surgeon in the Presbyterian Hospital from 1900 to 1903. Shortly afterwards he was appointed associate surgeon to the staff at that hospital. He was instructor in surgery at the Rush Medical College from 1903 to 1905. And during a leave of absence in 1906 and 1907, he spent a year in postgraduate study in Germany and at Vienna, Austria. Returning to Chicago in 1907, he decided to specialize in surgery and was associated with Dr. Arthur Dean Bevan, during which time he was invited to become a member of the Chicago Surgical Society, and the Western Surgical Association, of which organization he was a member until his death.

In October 1908 Doctor Smith moved to Wausau, establishing a practice in surgery and consultation. He cooperated with the hospital administration in organizing its first medical staff, and was chief of staff at St. Mary's Hospital from its organization in 1908 until his death.

He was a member of the Marathon County Medical Society and served two terms as its president. He was a member of the State Medical Society of Wisconsin from 1909, and president of the Society in 1926. He was a member of the Council for 16 years, and in 1934 he served on the committee of the Society which established the *Red Book*, containing the governing rules regarding admission to the Wisconsin General Hospital in Madison. He was a member of the editorial board of the *Wisconsin Medical Journal* for 12 years, and was secretary of the Ninth Councilor District Medical Society for 32 years and president for one year.

In 1937 Doctor Smith received the highest honor given by the State Medical Society, the Council Award. This award signifies distinguished service to medicine in Wisconsin and read as follows:

> "Joseph Franklin Smith—a son of Indiana, eminent surgeon and preceptor, active in civic affairs, 25 years secretary of the Ninth Councilor District Medical Society, 20 years councilor, 12 years member of the editorial board of the *Wisconsin Medical Journal*, two years alternate delegate and 16 years delegate to the American Medical Association, past president of the Marathon County Medical Society—for your inspirational effort within your district in furthering postgraduate work by quarterly

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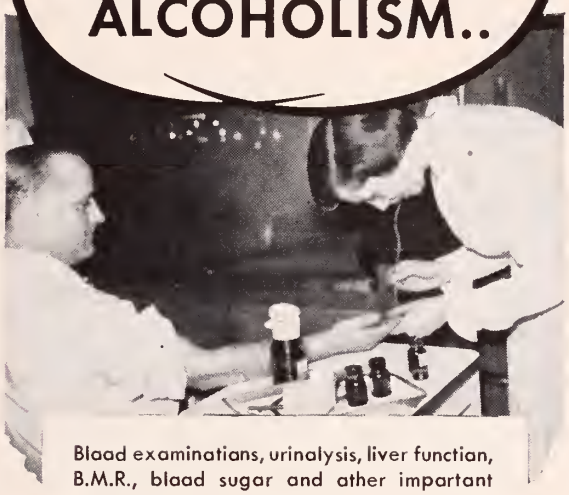

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meetings, for your distinguished service to scientific medicine and public protection, alike, as the sole creative force of the Council on Physical Therapy of the American Medical Association, and for your devotion over a quarter of a century to the furtherance of the aims and ideals of the organization of medicine in Wisconsin, we, your fellow members give you this seal of our society as a token of your achievement and of our esteem and affection."

He was a member of the American Medical Association during his entire career, and, as a member, served as a delegate from the State Medical Society for 21 years. In 1925 he introduced a resolution calling for the establishment of a council on physical medicine, which resulted in the establishing of the Association's present Council on Physical Therapy.

Doctor Smith was preceptor of the University of Wisconsin Medical School from 1926 to 1946, and in that capacity trained senior medical students of the University during their preceptorship at St. Mary's Hospital where he was also an instructor in St. Mary's School of Nursing. Up to the time of his death the students were greatly benefited by his outstanding seminars, which he gave to them with painstaking care and to which they looked forward with eagerness.

The doctor was also a member of the Wisconsin Surgical Society, the American College of Surgeons, the Chicago Surgical Society, and the Western Surgical Association, and the American Association of Railway Surgeons.

He contributed articles on medical and surgical subjects to the *Wisconsin Medical Journal* and to national publications; notable among them was one on leukemia research which was conducted by the doctor under a grant from the Rockefeller Institute.

He served as chairman of the Medical Advisory Board of five counties during World War I, and he was chairman and organizer of the Medical Defense Unit of Marathon County during World War II. He helped reorganize the Chamber of Commerce in Wausau and became its president for three years, and was a member of the board of directors for several years.

Active in Boy Scout work from the early days of its organization in Wausau, he received the Silver Beaver Award in 1936, given by President Hoover. At the time of his death he was a member of the National Council of Boy Scouts of America.

He was director of the Marathon County unit for Children's Crippled Aid Society for a number of years. He helped organize the Wausau Community Chest and was president of the Community Chest in the years 1932 to 1935, as well as a member of the Central Council from the time the Chest was formed in 1930.

He was a member of the Wausau Rotary Club from the time of its organization to the time of his death.

In 1946 the Marathon County Medical Society gave a testimonial dinner in Doctor Smith's honor. Dr. Herbert Christiansen presented a resume of Doctor Smith's professional and civic life and the society presented him with a gold wrist watch.

The Dr. Joseph Smith Medical Library, containing about 6,000 bound volumes of medical textbooks in English, German, and French, as well as bound volumes of periodicals, is located in St. Mary's Hospital, Wausau, and was given by Dr. and Mrs. Joseph F. Smith.

The doctor continued his practice up to his fiftieth jubilee in 1950, and he was honored at this time by the Marathon County Medical Society which presented a bouquet of 50 golden yellow roses in a gold bowl.

Doctor Smith is survived by his wife, Mary E. Smith.

Dr. Frank Morgenroth, 63, a Milwaukee physician from 1928 to 1938, died suddenly on May 12 in Los Angeles, California. He was head of the Overland Medical Clinic there.

Born in Milwaukee on January 17, 1889, the doctor took part of his medical training at Marquette University School of Medicine and received his medical degree from the Chicago College of Physicians and Surgeons. He served as a public health physician in Racine in the 1920's and was assistant state administrator of WPA in charge of health and sanitation in 1935 and 1936.

Survivors include his wife, a son, and two daughters.

Dr. Nicholas B. Wagner, former Racine physician, died at a hospital in Platteville on May 19. He was 73 years old.

Born in Chicago on July 13, 1878, the doctor graduated from Rush Medical College in 1910 and served his internship at the House of Correction Hospital in Chicago. He practiced in Port Edwards, Wis., and Eveleth, Minn., before moving to Racine where he established a practice in general medicine and served as industrial physician for the J. I. Case Company.

In 1929–1930 Doctor Wagner attended the University of Vienna, Austria, to specialize in eye, ear, nose, and throat work. He returned to Racine where he practiced until his retirement.

He is survived by his son, two sisters, and two granddaughters.

Dr. Henry Harder, retired Milwaukee physician, died on June 6 at his home. He was 81 years old.

Born on August 13, 1870 in New Holstein, the doctor taught school for a number of years before enrolling in Northwestern University Medical School. He was graduated from that institution in 1899 and then established his practice in Milwaukee. He retired from active practice in 1944.

Doctor Harder was a member of the Medical Society of Milwaukee County and the State Medical Society.

Survivors include his wife and a daughter.

535 North Dearborn Street, Chicago 10, Illinois

RICAN MEDICAL ASSOCIATION news notes

JULY, 1952

AMA news written especially for use in state medical journals

PR Workshop Set for September

School bells will be ringing for all state and county public relations personnel when "classes" convene September 4 and 5 at the first Public Relations Institute. Sponsored by the American Medical Association as a supplement to the annual Medical Public Relations Conference, the Institute will feature clinics on a variety of practical PR problems. The sessions, designed primarily for lay public relations employees of state and county medical societies, will be held at Chicago's Edgewater Beach Hotel.

AMA to Consult with Osteopaths

At its June meeting in Chicago, the AMA's House of Delegates refused to modify its interpretation of the status of osteopaths. A resolution which would have permitted physicians to teach in osteopathic schools was turned down by the House. It did recommend, however, that the Board of Trustees appoint a committee to meet with osteopathic leaders to discuss osteopathic education.

President's Commission Called Political Tool

The AMA's House of Delegates endorsed the stand taken previously by its officers in criticising the political motives of the President's Commission on the Health Needs of the Nation at its June meeting in Chicago. The Association believes that the commission was appointed in an adroit move to pull the question of socialized medicine out of the elections this fall.

Committee Report on Federal Medical Services

A progress report summarizing extensive research which is being conducted on federal medical services to dependents of servicemen and to veterans with non-service-connected disabilities, and the processing of patients between armed forces and veterans hospitals was submitted to the AMA's House of Delegates meeting in June. The special subcommittee expects to make a complete report, with specific recommendations, in December.

Tough Question

Can the federal government purchase health insurance from private carriers? Both Frank Dickinson, Ph.D., AMA economist, and Wendell Milliman, independent actuary, have pointed out that the moment the federal government becomes an insured of a private insurance company, it makes the sovereign power of government subservient to a private business institution. This creates a relationship contrary to public policy. This question is one of the most important and complex which must be considered by the medical profession.

AMA Surveys Doctors Released from Services

In an effort to find out how effectively the armed forces utilize medical personnel, the AMA's Council on National Emergency Medical Service currently is initiating a survey of doctors newly-discharged from active military service. From comments, suggestions and criticisms submitted by these physicians, the Council hopes to draw up an effective yardstick for re-examination of the doctor draft law which will be up for renewal July 1, 1953. Questionnaires are being sent to all physicians who have been discharged from service since June 25, 1950.

AMA Fellowship Officially Abolished

The AMA's House of Delegates officially abolished fellowship in the Association at its June sessions in Chicago. Provision has been made for service, affiliate and honorary fellowships to be incorporated in the membership classification. All candidates for membership in the Association will be screened by the Judicial Council prior to acceptance.

Question of Internship Up for Study

The whole status of medical internship—including supply and demand—is being re-studied by a special committee under the auspices of the AMA's Council on Medical Education and Hospitals. Dr. Victor Johnson, director of the Mayo Foundation for Medical Education and Research, is chairman of the committee which is made up of outstanding leaders in the hospital field throughout the United States.

Civil Defense Booklet Available from AMA

For the first time, a series of articles covering various medical problems involved in civil defense have been compiled in one booklet—"Medical Aspects of Civil Defense"—by the AMA's Council on National Emergency Medical Service. Included are items on civil defense organization, medical aspects of biologic warfare, chemical defense, atomic burn injury, nature of air raid casualties, mental health and atom bomb injury. Copies are being distributed to all chairmen of state emergency medical service committees. Additional booklets at 25 cents per copy are available on request through the Council.

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Address as follows: Medical Library Service, Service Memorial Institute Building, North Charter Street, Madison, Wisconsin.

Clinical Pediatric Urology. By Meredith Campbell, M.S., M.D., F.A.C.S., professor of urology, New York University Post-Graduate Medical School; Visiting Urologist, Bellevue and University Hospitals, New York. Philadelphia and London, W. B. Saunders Company, 1951. Price $18.00.

Urologist and pediatricians have looked forward to the publication of Doctor Campbell's "Clinical Pediatric Urology." This revision of the author's previous two volume "Pediatrics Urology" ranks as the most authoritative and comprehensive book in the English language concerning genito-urological diseases of the pediatric patient. The writer has, in addition, contrived to present a broad general text background of the entire field of urology. Extensive bibliographies of classical and recent contributions have been appended at the closure of each chapter.

Dr. Meredith Campbell's work reflects his widely accepted leadership in the field of pediatrics urology. Over 30 years of clinical experience with pediatric patients in the several medical centers of the metropolitan New York area is tabulated. It includes autopsy studies from nearly 50,000 cases including over 15,000 pediatric cases, and represents the combined efforts of pathologists, pediatricians, urologists, roentgenologists, and many technical assistants. Since 1937 many new illustrations, diagrams, and urographic prints have been added to the initial outstanding collection.

The chapter concerned with obstructive uropathies has been amplified and well illustrates Doctor Campbell's deep understanding and humanitarian interest in this phase of urological investigation and treatment. The subjects of *Embryology* and *Congenital Anomalies* again occupies an expectedly prominent place in this treatise of genito-urinary diseases of the young. The *Urinary Tract Infections* are brought up-to-date with addition of current treatment in the light of the newer antibiotics. Recent contributions to the literature of endocrinology have also been utilized. A chapter on *Nephritis and Allied Diseases in Infancy and Childhood,* con-

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tributed by Drs. Elvira Goettsch and John D. Lyttle, completes this extensive but concise text. —J. B. W.

The Medical Clinics of North America. Nationwide Number. Philadelphia and London, W. B. Saunders Company, 1951.

The numerous contributors to the symposium on lesions of the skin have presented subjcts of general interest. In most instances, the author is a recognized authority on the subject about which he has written. The antibiotics and antihistamines in the treatment of cutaneous lesions and hormones in acne vulgaris are evaluated. The nevi and keratoses are fully discussed. Baffling conditions like ocular-mucous membrane syndrome, peripheral vascular disease, disseminated lupus erythematosus, atrophic lesion of the glans penis, and lipid diseases are covered. The pigmentary purpuric diseases of the lower extremities and granulomas with eosinophilia are well drafted.

The same volume contains articles dedicated to the honor of William Sharp McCann, Dewey Professor of Medicine of the University of Rochester School of Medicine and Dentistry.

Here the Emotional Aspects of Obesity, the Sex Hormones and Growth, Genetics, Potential Applications of Antibiotic Combinations, Management of Recumbency, a discussion of Herpex Simplex Virus, Hemolytic Anemia concept, Colorado Tick Fever, Serological Test in Tuberculosis, Determination of Gastric Acidity Without Intubation, and Hypothrombinemia in Hyperthyroidism each form a separate essay.

This volume of Medical Clinics, which has many contributors covering a variety of subjects, is hereby recommended for its newer concepts of certain diseases as well as its many therapeutic suggestions.—S. A. M. J.

Paracelsus; Magic into Science. By Henry M. Pachter. New York, Henry Schuman, 1951. Price $4.00.

This well documented biography of one of the most controversial figures in renaissance medicine, shows both critical balance and a dramatic spirit. Copies of fine old etchings and woodcuts by contemporary artists, Rembrandt, Duerer, *et al.*, enrich the text, and a manifest appreciation of the character of the times in which Theophrastus lived, together with a broad chronological appendix, take the reader back in spirit and in thinking to the stormy early half of the sixteenth century. Paracelsus was both a creature of and in part a creator of this intellectual storm.

Reared in poverty, (his father a bastard, his mother a bondwoman) a dirty unkempt man, a necromancer, a wanderer on the face of his earth, friend of the commonest man, driven from town to town, never quite earning his medical degree, yet sought after by the sick of low and of high degree, envied and hated by the "doctors" who were

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jealous of his success and humiliated by his blistering tongue, Paracelsus emphasized the study of nature and the patient, rather than the dicta of Avicenna and of Galen. To medical students of his day, who hardly ever saw a patient, he cried, "The patients are your textbook." "At all the German schools, you cannot learn as much as at the Frankfurt Fair." He was stubborn and suspicious, arrogant and vindictive, yet exceedingly sensitive; he commonly chose the most inopportune times for his diatribes. He wrote endlessly, many of his statements are complete nonsense and contradictory, yet with flashes of wisdom. He at times counseled against the dirt pharmacy of his day and yet he used "mummy powder" insisting that the mummy should be human. "He recommended live toads against bubonic pustules; on foul wounds, he heaped three handfuls of steamed pigeon's dung."

With it all, he tried to see and to study the body as a physiologic unit. "Man is not unique, is not the center of the universe." (And remember Copernicus did not publish until 1543, after the death of Paracelsus.) He was forever consulting the stars, the signs of the zodiac and the moon phases, yet he writes, "The stars determine nothing, incline nothing, suggest nothing; we are as free from them as they are from us." This observer, experimenter, this creature of contradictions was consistently a fighter against intrenched privilege and against orthodoxy.

Read this book! You will enjoy it and in this present period of storm, strife and maledictions, so similar in many ways to the times of Paracelsus, you will be encouraged.—P. F. C.

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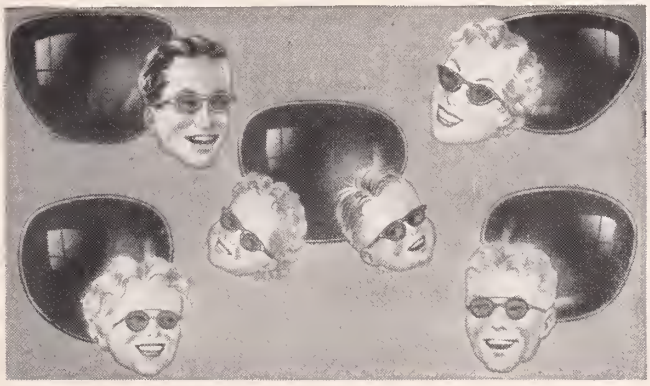

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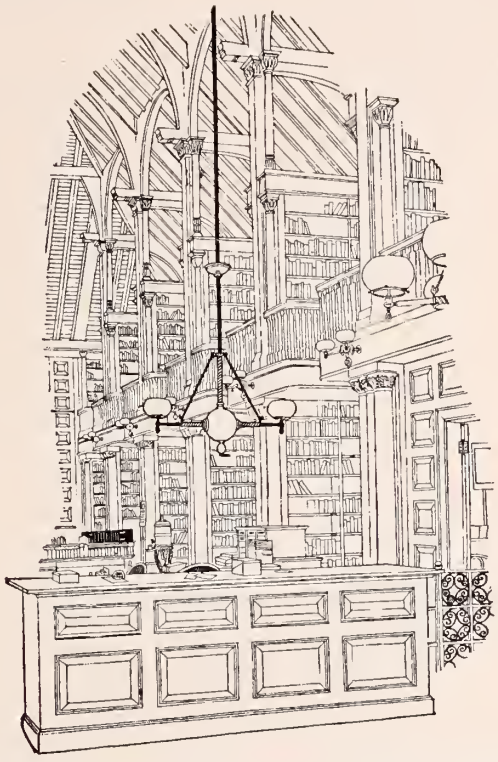

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Crawford	O. E. Satter Prairie du Chien	H. L. Shapiro Prairie du Chien	
Dane	G. H. Ewell Jackson Clinic Madison	G. C. Hank 110 E. Main Madison	Second Tuesday
Dodge	C. L. Qualls Beaver Dam	R. E. Urbanek Beaver Dam	Last Thursday*
Douglas	C. T. Droege 1507 Tower Superior	R. T. Anderson 1507 Tower Superior	First Wednesday** Badger Room of the Hotel Superior
Eau Claire–Dunn–Pepin	W. G. Cameron 131 S. Barstow Eau Claire	H. E. Sorensen 314 E. Grand Eau Claire	Last Monday
Fond du Lac	R. W. Steube St. Agnes Hospital Fond du Lac	H. R. Sharpe, Jr. 92 E. Division Fond du Lac	Fourth Thursday*
Forest	O. S. Tenley Wabeno	B. S. Rathert Crandon	
Grant	N. G. Rasmussen Montfort	H. W. Carey Lancaster	Last Thursday, March, June, Sept. and Nov.
Green	D. D. Ruehlman Monroe	L. G. Kindschi Monroe Clinic Monroe	
Green Lake–Waushara	Roy Hong Wild Rose	R. S. Pelton Markesan	Last Thursday, every other month starting in Jan.

List of Officers and Scheduled Meetings of County Medical Societies—Continued

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Iowa	C. L. White Mineral Point	H. M. Walker Dodgeville	First Thursday following first Monday
Jefferson	E. A. Miller 133 Riverlawn Watertown	E. J. Netzow Lake Mills	Third Thursday*
Juneau	J. S. Hess Mauston	M. S. Tverberg Mauston	Second Tuesday Hess Clinic in Mauston
Kenosha	H. L. Schwartz 625 57th Kenosha	Helen A. Binnie 7609 25th Kenosha	First Thursday* Elks Club Kenosha
La Crosse	J. J. Satory 1707 Main La Crosse	D. M. Buchman 308 Newburg Bldg. La Crosse	Third Monday
Lafayette	D. J. Garland Shullsburg	N. A. McGreane Darlington	First Tuesday
Langlade	D. W. Dailey Elcho	F. H. Garbisch Antigo	Second Wednesday
Lincoln	L. J. Bayer Merrill	J. D. Millenbah Merrill	
Manitowoc	C. J. Radl Wood Block Manitowoc	W. C. Randolph 819 Hancock Manitowoc	Last Thursday
Marathon	D. M. Green Trust Bldg. Wausau	G. R. Hammes 529½ 3rd Wausau	
Marinette–Florence	J. M. Bell 1723½ Main Marinette	R. J. Rogers Oconto	Third Wednesday St. Joseph's Hospital
Milwaukee	N. J. Wegmann 2510 W. Capitol Milwaukee	W. T. Casper 2218 N. 3rd Mr. J. O. Kelley, Ex. Sec. 208 E. Wisconsin	Second Thursday
Monroe	C. E. Kozarek Tomah	J. S. Mubarak Tomah	Third Monday
Oconto	H. A. Aageson 1113 Main Oconto	G. R. Sandgren Suring	
Oneida–Vilas	G. R. Thuerer 1020 Kabel Rhinelander	Marvin Wright 1020 Kabel Rhinelander	Monthly
Outagamie	L. B. McBain 128 N. Durkee Appleton	W. A. Adrians 118 W. College Appleton	Third Thursday* Elks Club 6:30 p.m.
Pierce–St. Croix	E. F. Hill Spring Valley	P. H. Gutzler River Falls	Third Tuesday
Polk	W. A. Fischer Frederic	G. B. Noyes Centuria	
Portage	M. G. Rice Stevens Point	H. A. Anderson Stevens Point	
Price–Taylor	J. L. Murphy Park Falls	J. J. Leahy Park Falls	Last Saturday, Feb., May, Aug., and Nov.
Racine	J. M. Albino 710 Main Racine	J. G. Jamieson 812 Main Racine	Third Thursday
Richland	J. I. Spear Richland Center	L. M. Pippin Richland Center	First Tuesday Richland Hospital
Rock	M. M. Baumgartner 508 W. Milwaukee Janesville	J. F. Pember 508 W. Milwaukee Janesville	Fourth Tuesday
Rusk	L. M. Lundmark Ladysmith	M. L. Whalen Bruce	First Tuesday
Sauk	E. V. Stadel Reedsburg	J. J. Rouse Reedsburg	Second Tuesday*
Shawano	J. H. Terlinden Bonduel	R. C. Cantwell Shawano	Third Tuesday
Sheboygan	J. E. Martineau Elkhart Lake	J. F. Hildebrand 1011 N. 8th Sheboygan	First Thursday
Trempealeau–Jackson–Buffalo	F. T. Weber Arcadia	E. P. Rohde Galesville	Third Thursday
Vernon	L. F. Gulbrandsen Viroqua	C. A. Ender Viroqua	Last Wednesday
Walworth	R. S. Galgano Delavan	K. C. Bill Elkhorn	Second Thursday*
Washington–Ozaukee	P. B. Blanchard Cedarburg	K. F. Pelant Grafton	Fourth Thursday
Waukesha	J. C. Frick 262 W. Broadway Waukesha	J. A. Bartos 707 Oakland Waukesha	
Waupaca	L. G. Patterson 122 S. Main Waupaca	R. E. Bolinske Clintonville	
Winnebago	W. E. Clark 19 Jefferson Oshkosh	B. S. Greenwood 19 Jefferson Oshkosh	First Thursday
Wood	E. E. Debus Wisconsin Rapids	R. W. Mason Marshfield	Four times a year

* Except June, July, and August.
** Except July and August.

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*Frost, L. H., and Jackson, R. L.: J. Pediat., 39:585-592 (Nov.) 1951

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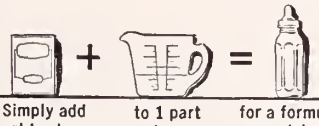

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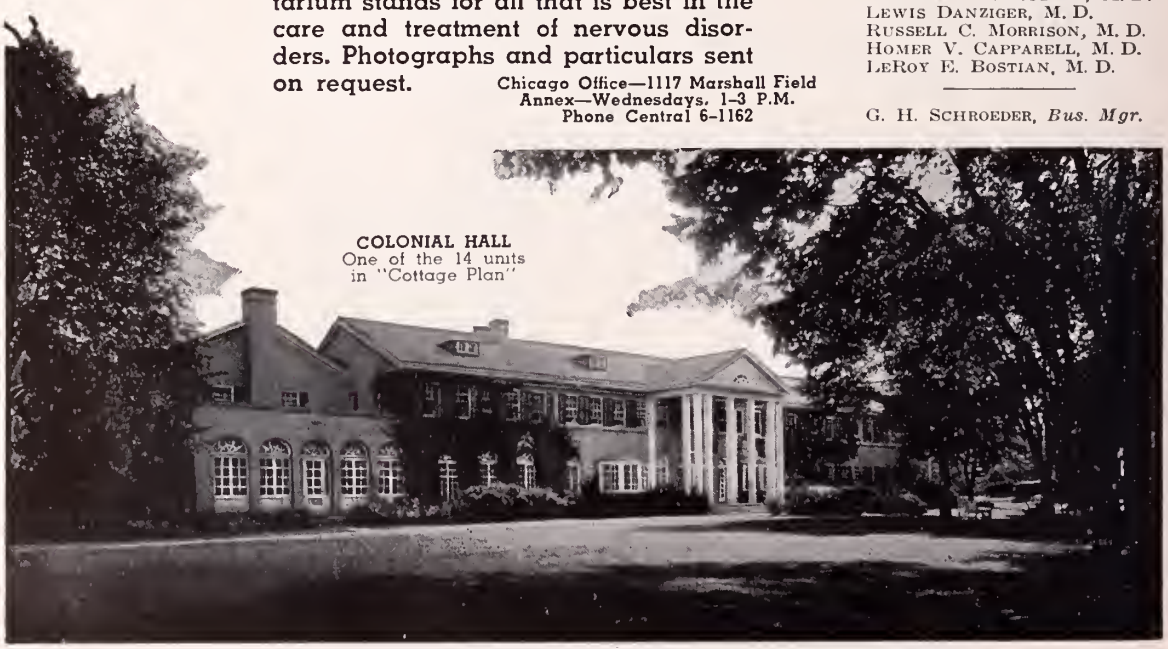

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Volume 51
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1. Von Alyea, O. E., and Donnelly, Allen: *Arch. Otolaryng.*, 49:234, Feb., 1949.

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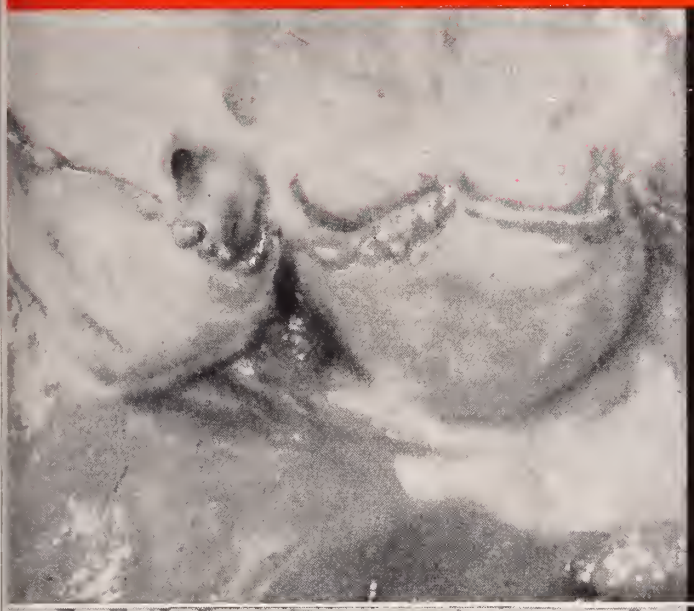
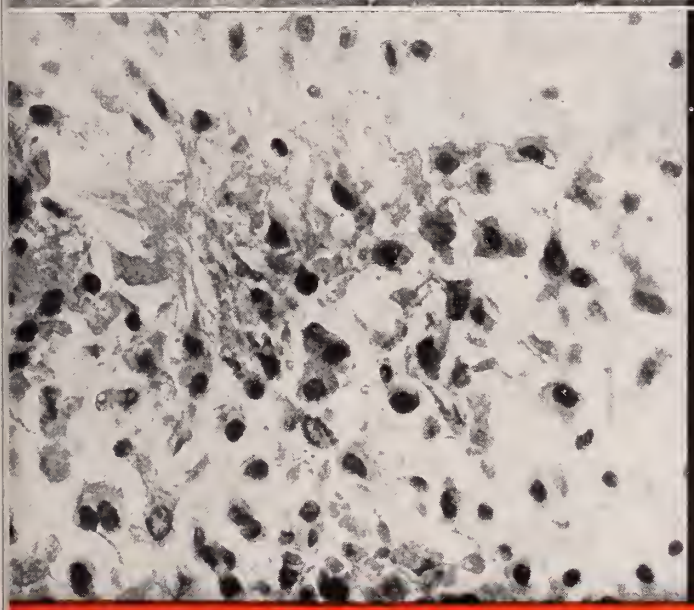
response in rheumatic fever



q. Does cortisone influence the heart lesions of rheumatic fever?

a. Early cortisone administration suppresses and in some cases may even prevent serious cardiac damage.



q. What effect does cortisone have on acute rheumatic fever?

a. Often within 24 hours after cortisone therapy, the severely ill, toxic patient appears alert and comfortable; and within one to four days, temperature drops to normal, appetite increases, and polyarthritis subsides.

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1. Kaufman, R., and Farmer, L. (1951), Norisodrine by Aerohalor in Asthma, Ann. Allergy, 9:89, January-February. 2. Swartz, H. (1950), Norisodrine Sulphate (25 Per Cent) Dust Inhalation in Severe Asthma, Ann. Allergy, 8:488, July-August. 3. Krasno, L., Grossman, M., and Ivy, A. (1949), The Inhalation of 1-(3',4'-Dihydroxyphenyl)-2-Isopropylaminoethanol (Norisodrine Sulfate Dust), J. Allergy, 20:111, March.

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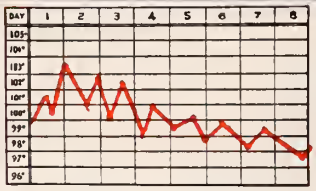
URINARY TRACT

Pyelonephritis

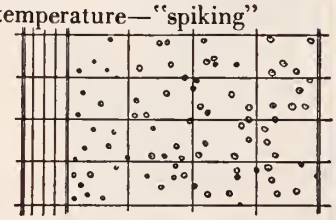
1 Pyelonephritis occurs most often in the young child . . .

commonest in the "diaper-age" female

2 The onset is sudden, usually with a chill . . .



. . . temperature—"spiking"

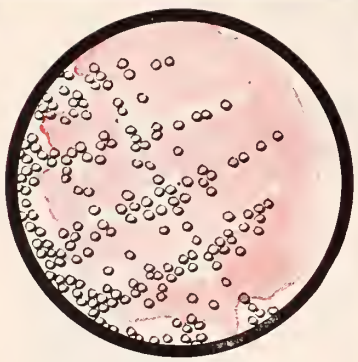


. . . white cell count—high

3 Always, pus cells and bacter pear in the urine

look for *clumps* of white cells in *catheterized* specimens

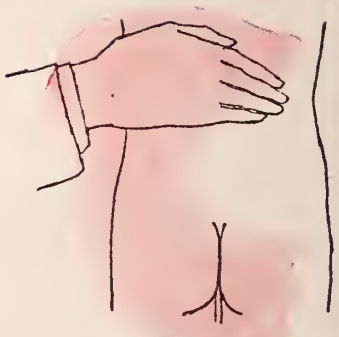
4 Culture determines pathogen. Mixed infection not uncommon.



in 8 out of 10 children, colon bacillus invades

5 Sometimes there is tenderness over the kidney region . . .

try the McKnight punch, or

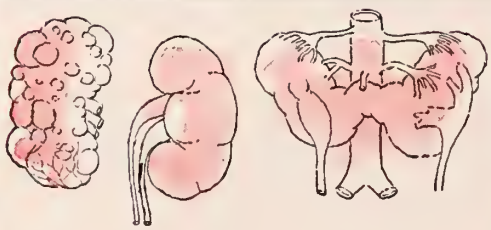


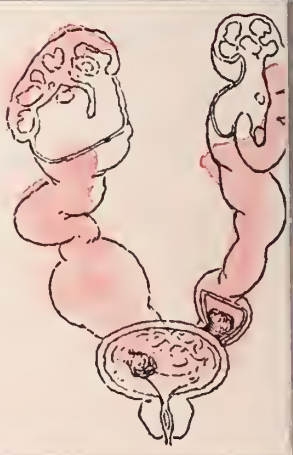
palpation in C-V angle

6 . . . or abdominal pain and rigidity

suggestive of an acute abdomen

7 Look for a cause of urinary stasis.





in children, 75% have congenital malformation . . . others may have calculus, foreign body, neoplasm, ureteral spasm.

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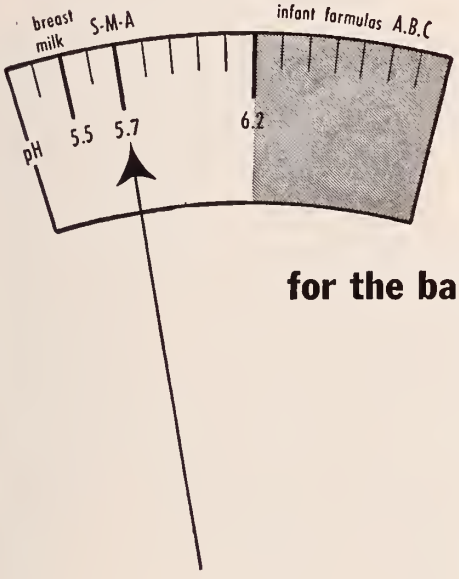

- produces a stool with a pH "practically identical" with that of the infant fed human milk. Stools of babies fed other formulas are distinctly more alkaline (6.2 to 6.7).[1]

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2 *Lower incidence of constipation.* Formation of calcium soaps is inhibited; acid produced by fermentation stimulates peristalsis.

3 *Lessened susceptibility to diarrhea.* Lactobacilli inhibit overgrowth of 'colon' group bacilli.

4 *A stool typical of the breast-fed infant*—having a "buttermilk-like", rather than putrefactive odor.

5 *Vitamins more readily available, especially vitamin B_{12}.* Growth of putrefactive organisms which reduce amounts of vitamins available[2] is inhibited.

6 *Minimal danger of perianal dermatitis and diaper rash in the new-born.*[3]

REFERENCES

1. Barbero, G.J., Runge, G., Fischer, D., Crawford, M.N., Torres, F. E., and Gyorgy, P.: J. Pediat. *40*:152 (Feb.) 1952.
2. Watson, J.: Gordon Research Conf. Vitamins and Metabolism, 1950.
3. Torres, F.E., Romans, I.B., and Wheller, J.B.: A Study of Infantile Diaper Rash. To be published.

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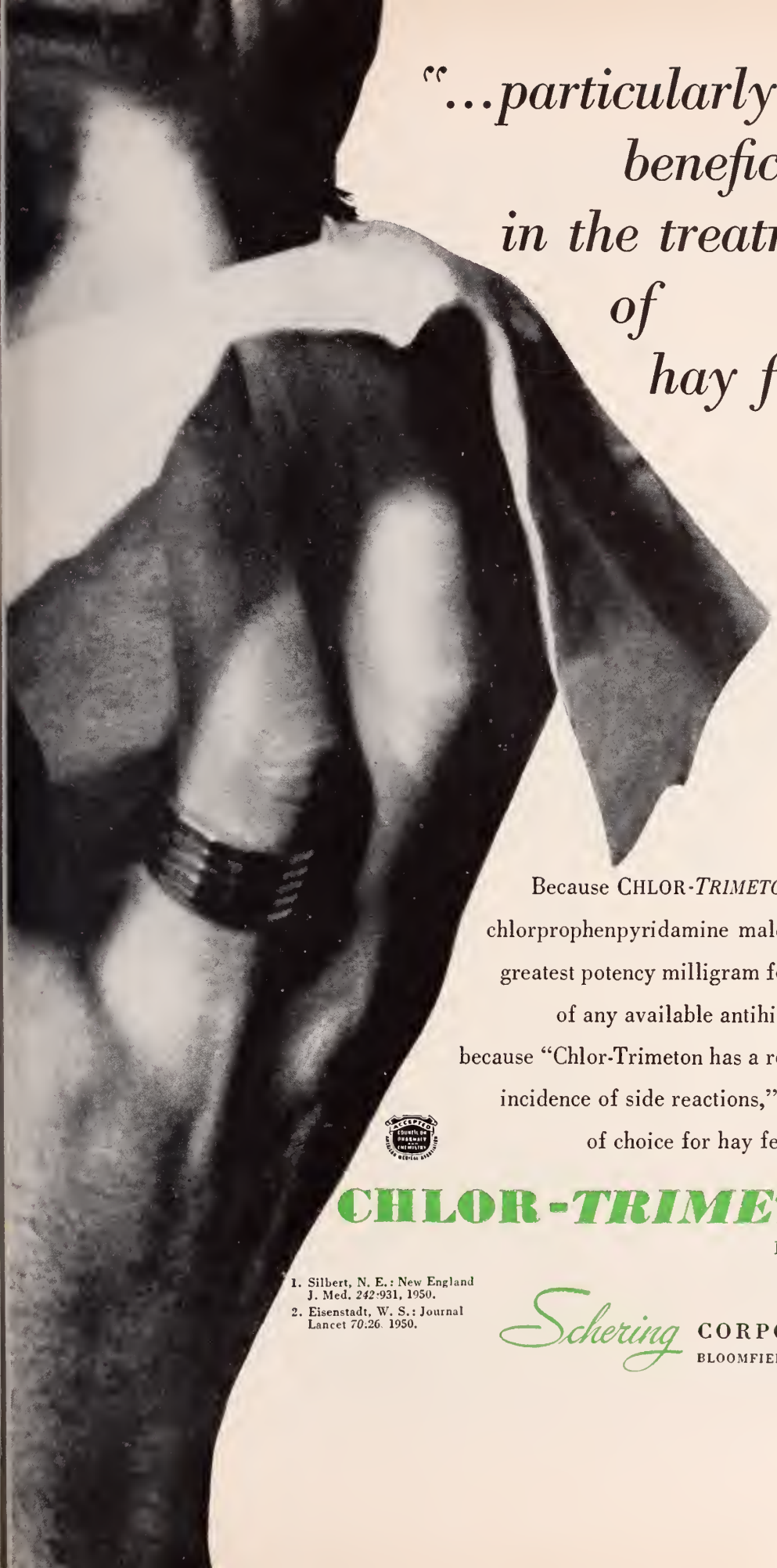

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1. Silbert, N. E.: New England J. Med. 242:931, 1950.
2. Eisenstadt, W. S.: Journal Lancet 70:26. 1950.

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« « « EDITORIALS » » »

The Use of ACTH and Cortisone in the Treatment of Rheumatic Fever

A Preliminary Statement on the Cooperative Rheumatic Fever Study

Early in 1951 an international study of the treatment of rheumatic fever was set up with the object of measuring the relative values of ACTH, cortisone, and aspirin. This cooperative study, first of its kind in this field, is being conducted in 13 research centers in the United States, Great Britain, and Canada by the American Heart Association's Council on Rheumatic Fever in conjunction with the British Medical Research Council.

A preliminary report of the findings, made by a panel of investigators engaged in the study at a joint scientific session of the Council on Rheumatic Fever and the American Rheumatism Association in Chicago on June 7, 1952, was summarized as follows:

"A group of investigators in the United Kingdom, Canada and the United States initiated in January 1951 a cooperative study on the relative value of ACTH, cortisone and salicylates in the treatment of rheumatic fever and the prevention of rheumatic heart disease. The plan of study provides for uniform criteria for the diagnosis of rheumatic fever and for the degree of rheumatic activity required for the admission to the study, the random allocation of patients to the three treatment groups, a defined dosage schedule of the drugs for a fixed period of time, a specified period of observation following treatment and a long term follow up schedule. It also lays down precisely the frequency and type of clinical and laboratory observations to be carried out on each patient.

"To date, in all three countries, 658 cases have been admitted to the study and the analysis of rather less than half of these is the basis of the preliminary report. These cases were analyzed for changes in those symptoms, signs and laboratory observations usually considered important in evaluating the course of acute rheumatic fever. In the type of cases admitted to the trial and with the regime of treatment laid down, it appears that individual symptoms, signs or laboratory observations may have been affected more favorably by one or another of these three drugs, but no consistent pattern is evident. In short, no firm conclusions can at present be drawn concerning the drug most effective in the control of the acute illness. The cases have not been under observation sufficiently long to provide data on the prevention of rheumatic heart disease.

"Admission of new cases to the study will be brought to an end later this year. It is anticipated that a total of 750 cases will be available in all three countries for complete and detailed analysis of the effects of the drugs on the acute course of the disease and later, after adequate follow up, on the prevention of rheumatic heart disease."

An Appreciation

Recently the "Badger Report" came across my desk and it was with intense interest that I noticed that two men of the School of Medicine were retiring, namely, professors J. A. E. Eyster and Paul F. Clark. As far as I know, upon the retirement of these two, all of the men who taught the basic sciences at the School of Medicine when I was a student (1915–1917) are now either retired or dead.

It is in the nature of things that teachers finally retire. I wonder, however, if we appreciate fully the outstanding group of men who taught during the early years which I mentioned. Let me name them (essentially in alphabetical order): Charles R. Bardeen, Dean and professor of anatomy; Charles Henry Bunting, professor of pathology; Harold C. Bradley, professor of biochemistry; Professors J. A. E. Eyster, Walter Joseph Meek and Percy M. Dawson, all of the physiology department; Arthur S. Loevenhart, professor of pharmacology, and last but not least William Snow Miller, professor of microscopic anatomy.

What a galaxy of stars! These men were not only nationally but internationally known. I have been associated with medical schools either in the role of a student or a teacher since I left the University of Wisconsin in 1917. I have met many great research men and teachers in the past 35 years. The fact that I have had this experience makes me appreciate still more the men under whom I took the major part of my basic science work. The University of Wisconsin is a world-renowned institution. I am proud that I hold two degrees from it. The thing which makes an institution great is not the marvelous layout of its campus, or the magnificence of its buildings, or the charm and location of the town in which it is located, but rather the excellence of its teachers. Those I have mentioned rank among the great; they would have adorned any campus and added luster to any institution. I salute them all.—Edward J. Van Liere, *Dean, West Virginia University School of Medicine, Morgantown, W. Va.*

Is Your Theater Telling Your Story?

Has your local theater billed the thrilling story of the medical profession? Every Doctor of Medicine in America has a feature role in a new film entitled "Your Doctor." It is being offered to all commercial theaters in Wisconsin for showing between now and December.

"Your Doctor" is an exciting documentary presented by RKO–Pathe, Inc., and produced in cooperation with the American Medical Association. In it, theater audiences learn how physicians are made; see the medical student develop through the stages of student-intern-resident to practicing physician; go with him on emergency calls; are shown the role of teaching, research, general practice and specialties in the provision of high quality medical care to the people of America.

"Your Doctor" is being offered to Wisconsin theaters through RKO Radio Pictures of Milwaukee. As theaters are billed for the showing, the State Medical Society is notified and local physicians will be informed of the scheduled appearance.

Literally millions of Americans will view this film in the next few months. It is one of the great public relations achievements of the American Medical Association on behalf of the physicians of the country. Urge your patients to see this film. And be sure to see it yourself. It is your story as the AMA has told it to your patients.

A New Emphasis on Teaching

For the past several years the Council on Scientific Work has sought to develop programs in connection with the Annual Meeting which would have more direct application to practice than the didactic lectures provided as headline events of previous meetings. To what extent that objective has been attained can be gauged from the summary of the programs outlined in a special section of this issue of the *Journal.*

A review of the 1952 Annual Meeting program will show to what extent emphasis has been placed upon direct teaching experience. It will be noted that the first hour of each day is devoted to a series of teaching programs which it is hoped will have wide appeal. The Wisconsin Society of Obstetrics and Gynecology has assisted the program committee in preparing three programs which should prove very practical for general practitioners; the fracture demonstrations will be carried on in the same manner as they were for the past two years, with the cooperation of the Wisconsin Orthopedic Society; and likewise the x-ray interpretations will provide material of practical value for many physicians.

In addition to the morning teaching programs it will be noted that several important related demonstrations will be held each day: one on manual artificial respiration, provided by the Wisconsin Society of Anesthesiologists in cooperation with the VA Hospital, Wood, and Marquette University School of Medicine; a gross tissue display provided by the Wisconsin Society of Pathologists; and a daily demonstration of dissections conducted by members of the Anatomy Department of the University of Wisconsin Medical School.

Perusal of the program will also show that the Council has eliminated section meetings as such, with the exception of the Section on Ophthalmology and Otolaryngology.

The Council on Scientific Work hopes that its efforts will meet with your approval.

Comments from the Wisconsin Press

Ulcers on Television?

"For the first time in history a major surgical operation has been televised for a general audience. The telecast was from a Chicago hospital where surgeons removed a part of the stomach of a 60-year-old man. The program aroused much interest among those who watched it over TV and occasioned much comment, most of it favorable. Televising operations as a novelty might be all right, but there is always the danger that TV producers will run a good thing into the ground. In time, operations might become as wearisome as the soap operas. Viewers might be cautioned not to miss the next exciting chapter of 'John's Other Ulcer.' Some operations are lengthy. Under the influence of television a man's appendix might be removed one day and he might be sewed up the next. A surgeon who gave a particularly good performance removing a patient's tonsils would feel encouraged to remove his adenoids as an encore.

"But there is one tremendous advantage which could come from telecasts of operations. The person who always feels compelled to give a cut by cut account of his time in the operating room may be silenced forever if the opening remark 'About my last operation,' could be answered with a casual, 'Yes, I know, I saw it on television'."—WAUKESHA FREEMAN, June 16, 1952.

* * *

Auxiliary Sets Example

"Wisconsin faces a shortage of elementary teachers that seems certain to be the worst ever . . . . The nurses' associations in the state are trying hard to get girls into nursing training . . . The hospitals are working constantly. . . The State Medical Society of Wisconsin is giving all-out support.

"The woman's auxiliary of the society is putting on a state-wide recruiting program. Twelve local units of the auxiliary are offering scholarships and loans for student nurses. County units of the auxiliary distributed nurse recruitment literature to pupils in 500 Wisconsin high schools this spring. Doctor's wives visited principals and counselors in high schools, explaining the need and opportunities for girls in the field of nursing, and asking help in recruiting.

"It's that kind of personal effort and that kind of push that is needed in the field of teacher recruiting."—MILWAUKEE JOURNAL, June 11, 1952.

* * *

Some Progress Made

"There is room for improvement in reporting medical news on a local level, with both the press and doctors co-operating, an opinion summary just issued by the State Medical Society of Wisconsin reveals.

"The report, issued by Dr. A. H. Heidner, president of the society, is based on a medical-press conference held recently in Sheboygan.

"Out of the conference came a general understanding that each county medical society should have a public relations representative to whom the press could go for advice; "miracle" drug stories should be checked by newspapers with local physicians before printing them; both sides should make an effort to comprehend the other's viewpoint.

"Further discussion between the county medical society and the representatives of the press were recommended with the idea of setting up machinery for more efficient co-operation between the two groups. This is the only way to better understanding and a working relationship."—TWO RIVERS REPORTER, July 1, 1952.

* * *

"Pointed Paragraph"

"This writer had the opportunity to accompany Dr. P. H. Gutzler, B. H. Kettlekamp and Wayne Wolf to La Crosse Thursday evening to attend a Medical Association and Press meeting. The meeting was well attended by editors and doctors from the near-by areas of La Crosse. Much discussion was made about whether newspapers should publish polio victims' names and addresses. In La Crosse there is apparently friction between the Board of Health and the newspapers which resulted in this discussion. There seems to be a greater need for better public relations and better understanding between the doctors and the press, and I feel that this meeting did a lot to bring out problems confronting each group. After the meeting the editors and doctors sat down and enjoyed a snack lunch."—BELDENVILLE REPORTER, June 26, 1952.

Epidermolysis Bullosa Hereditaria in a Newborn

Report of Two Cases

By MARVIN S. KAGEN, M. D., LLOYD WILLIAMS, M. D., WALTER GIFFIN, M. D.
Appleton
and RALPH WILEY, M. D.
Iola

EPIDERMOLYSIS bullosa hereditaria[1] is a rare disease which is characterized by a hereditary background and the formation of blisters following trauma. The blisters appear at various ages, and the disease is often classified according to the age at which the eruption appears.

Simple epidermolysis bullosa is a benign hereditary skin disease in which blisters are superficial and do not result in scarring. This is a dominant hereditary disease with the vesicles or blisters occurring in the epidermis. The blisters usually occur on the knees, soles of the feet, elbows, and the dorsum of the hands. The blisters do not occur on the mucous membranes. The condition often disappears at the time of puberty.

Dystrophic epidermolysis bullosa involves the mucous membranes as well as the skin. The blisters which form may be deep and involve the corium, healing slowly with scarring. With the formation of blisters under the fingernails, the fingernails are shed and do not return. The condition may occur early or late in life. The formation of the teeth, bones, and growth may be affected when the condition occurs in the newborn. Blisters forming about the conjunctiva and cornea may result in blindness. The superficial layers of the tongue and skin may be easily removed with a rubbing action. This test is known as a positive Nikolsky's sign. The condition may persist for years or result in death.

Epidermolysis bullosa of the newborn is considered the most severe form of this disease. The blisters are present at birth. The mucous membranes, skin, and nails are involved. A positive Nikolsky's sign is present.

Report of Two Cases

Case 1.—R. M. was born on Sept. 15, 1951. He was the fourth child of young healthy parents. There was no history of consanguinity or any previous epidermolysis bullosa.

At birth, dime-sized blebs were noted over the right parietal area and the left iliac prominence. The parents and the newborn's Kahn tests were negative. The newborn received penicillin intramuscularly for five days. During this period, there was a marked increase in blisters on the buttocks, legs, elbows, and chest. Six cubic centimeters of serous fluid were removed from one of the large blisters. Blisters would appear within a few hours after trauma. Bullae also appeared on the gingiva and the palate. Physical examination was negative except for the lesions on the mucous membranes and the skin.

Fig. 1.—R.M., case number 1.

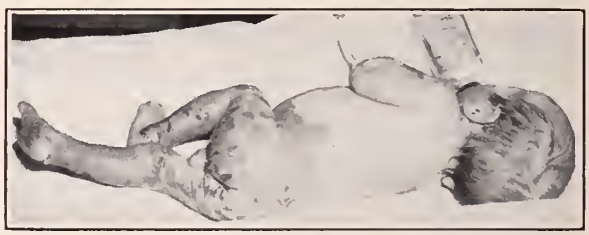

Fig. 2.—R. M., case number 1.

Ten milligrams of ACTH were given daily in four divided doses for 96 hours with no beneficial effect. The infant was irritable and ravenously hungry while receiving ACTH. After stopping ACTH, he was satisfied with an isocaloric diet and seemed more comfortable. Aureomycin ointment was applied locally in order to discourage secondary infection. The infant continued to develop new blisters and died on Oct. 19, 1951, at six weeks of age. Autopsy permission was not obtained.

Case 2.—M. F., a white male, was born on Nov. 24, 1949.

There was no history of consanguinity or any previous epidermolysis bullosa in the family. The mother was 33 years of age and had a daughter 12 months of age who was in excellent health. A brother and sister of the mother were living and well. Her parents had died of heart disease.

The father was 35 years old. His father, three brothers, and a sister were living and well. His mother had died of heart disease. Two siblings of the father were premature and died at about five months of age.

Denudation of the skin on the left thumb, a great toe, and the thighs was present at birth.

Fig. 3.—M. F., case number 2, at one year of age.

On Dec. 29, 1949, clear blisters were present on the scalp, back, chest, face, and buttocks. The left toenail had been raised up by an underlying blister and then sloughed off, leaving a granulating wound. The Rh factor was positive, and the Kline test was negative. During this time, the child had to be kept on his back, because huge blisters would occur on his elbows and knees if he were turned on his abdomen. Blisters appeared on areas of friction. The blebs were tense and filled with straw-colored fluid. The blisters often extended along the margins, with the fluid raising the adjacent epidermis. A red granular base was present when the top of the blisters ruptured.

On Jan. 17, 1950, blisters appeared on the roof of the mouth. Large blisters continued to appear on the back of the scalp, back, and buttocks.

By March 2, 1950, all of the nails had been lost. The child had difficulty in eating because of the lesions in the mouth and the formation of blisters in the nasal passages followed by crusts.

In June 1950, a granulating wound had appeared on the posterior aspect of the scalp. A 1:6000 solution of potassium permanganate, bacitracin ointment, aureomycin ointment, and penicillin internally were used to help control the secondary infection.

The child continued to get more bullae at all times. He had difficulty in eating and gradually became thinner. He died on March 25, 1951, at 16 months of age.

On Nov. 14, 1950, the mother gave birth to her third child, a boy, who is normal.

Histopathology

In epidermolysis bullosa hereditaria,[2] unilocular vesicles and bullae may be located in any layer of the epidermis. As a rule, the vesicles and bullae are subepidermal in the dystrophic form and subcorneally in the simple form. Edema and a mild to moderately severe chronic inflammatory infiltrate is present in the upper corium.

Recent reports suggest that in the simple form the elastic tissue is usually normal, while in the dystrophic form the elastic tissue tends to be fragmented or absent in the upper corium. It is probable, however, that the absence of elastic tissue in the dystrophic form is not primary but secondary to its destruction by the disease process.

Discussion

Inheritance[3] of the disease occurs by heterozygous dominant and recessive genetic transfer. The dominant transfer of the disease appears to be associated with a much milder form, for usually just the palms, soles, and knees are involved. Recessive transfer of the disease occurs in the severe form with the skin, hair, nails, and mucous membranes being involved. The disease may have started from a mutation in the genes, which was then transferred to the offspring.

No family history of epidermolysis bullosa hereditaria was obtainable in either case. It is likely that the parents had the heterozygous recessive character for epidermolysis bullosa, and that the disease can be expected to appear in 25 per cent of their offspring.

Murray Robinson[4] in an excellent review of the subject points out that epidermolysis bullosa hereditaria is a symptom complex which should cover all forms of the disease, regardless of severity or time of appearance. The disease may appear as blisters on the toes and soles, associated with hyperhidrosis and be mistaken for epidermophytosis. Usually, a family history of the parents, uncles, cousins, and siblings having the same problem can be obtained in the mild cases.

When the disease is present at birth, it is usually severe and results in the loss of the nails, interference with dentition, leukoplakia on the palate, and scarring on the skin with disfigurement of the hands and feet. As in the cases presented, death may result. However, if the disease is not quite as severe, the individual may reach adulthood and lead a normal life except for the disfigurement.

A severe form of the disease with blisters on all areas of friction may appear in adulthood and may result in scarring on the skin and mucous membranes, blindness, and death.

Summary

1. Epidermolysis bullosa hereditaria is genetically transferred or transferable.

2. Usually, a similar severity of symptoms is transferred.

3. All treatment is symptomatic because it is not possible to correct an inherited defect at the present time.

4. Epidermolysis bullosa hereditaria in a newborn may produce death within a few years, or in a milder form may allow the patient to reach adulthood and lead a normal life except for the disfigurement.

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The 1951 Epidemic of Poliomyelitis in the City of Milwaukee*

By MAX J. FOX, M. D.
Milwaukee

IN THE year 1951, the city of Milwaukee had the most severe epidemic of poliomyelitis in its recorded history. Five hundred twelve cases were recorded and confirmed either at home or at South View Hospital. These cases were introduced from Milwaukee and the Milwaukee area. The first case entered South View Hospital in January 1951. Sporadic cases occurred from time to time until the epidemic assumed its height, with a gradual decline of cases continuing throughout the month of December. In the latter part of July the number of cases averaged 20 to 25 per week, and it was thought that the disease had reached its peak. The height of the epidemic, however, occurred in the month of August. For the second, third, and fourth weeks of that month, the respective number of new cases totaled 34, 34, and 35. By the end of August a noticeable decline in cases was observed, but even in the months of October and November there were weeks in which a large number of cases were reported. Many of these, however, were cases not previously recognized. An interesting feature which was revealed as the epidemic assumed its height was the extremes of age affected with poliomyelitis. The youngest child was 6 weeks of age and the oldest adult was 48. In a previous publication[1] we cited a case and postmortem findings of a 68 year old male. He represented the oldest case in the medical literature.

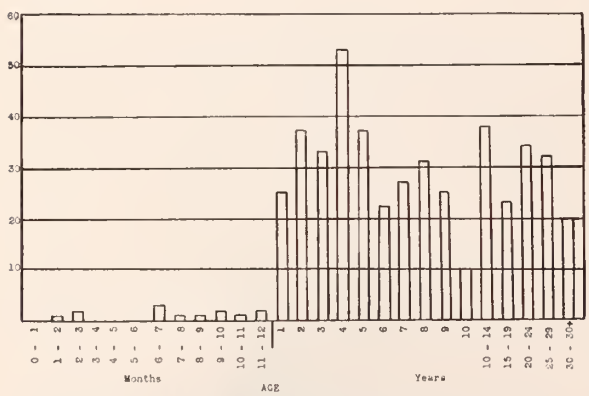

Chart 1.—Age distribution of the polio cases during 1951.

Chart 1 and table 1, when compared to previous years, reveal in a striking manner the large increase of cases in patients under 5 years and over 20 years of age. The 0 to 5 year age group showed

TABLE 1

Year	1951	1947	1946	1937
0 to 5 years	43.2%	26.4%	31.2%	35.3%
6 to 10 years	24.7%	27.6%	26.1%	26.5%
11 to 15 years	8.3%	20.7%	21.9%	17.7%
16 to 20 years	5.0%	5.8%	8.8%	7.8%
21 to 30 years	14.4%	8.0%	7.8%	3.9%
30+ years	4.4%	11.5%	4.2%	8.8%
Total number of cases	459	87	215	102

an increase in cases of 12 per cent over the average of previous years, whereas an increase of 15 per cent was observed in cases of 20 years of age. Fourteen infants under the age of 1 year are included in the former group. In addition to a slight decrease in cases in the other age levels, there was a marked decrease in cases in the 11 to 15 year age groups. In this age group only 8.3 per cent of total cases were noted, compared with an incidence of 19.3 per cent in the years 1936, 1947, and 1948.

TABLE 2—*Percentage distribution according to sex*

Year	1951	1947	1946	1937
Per cent of males	59.3	55.1	51.6	52.9
Per cent of females	40.7	44.9	48.4	47.1
Total number of cases	459	87	215	102

Table 2 presents the sex incidence. A 6.6 per cent increase of cases in males over previous years is noted. The age-sex correlation as shown in chart 2 again indicates the preponderance of males. Chart 2 also indicates that this preponderance was in evidence only below the 15 year age group, while above this age group the females tend to be in a majority. The males outnumbered the females in a ratio of 65:35 in the 0 to 15 year age group; but only 41.3 per cent above 15 years were male. Several concepts have been tendered as to why this situation occurs. It is interpreted that more males are susceptible before the period of puberty, and that a high estrogen content, postpuberty, makes the female more susceptible. This explains the higher incidence of poliomyelitis in females above 15 years of age and in pregnant women. Also, since fewer females contract poliomyelitis before 15 years of age, a less immunologically resistant female population above 15 years results. This will not bring about an abrupt shift as we find but rather a gradual shift in distribution so we must consider the endocrine relationship a contributing factor rather than the major cause.

*From the Department of Internal Medicine, Marquette University School of Medicine and the South View Isolation Hospital.

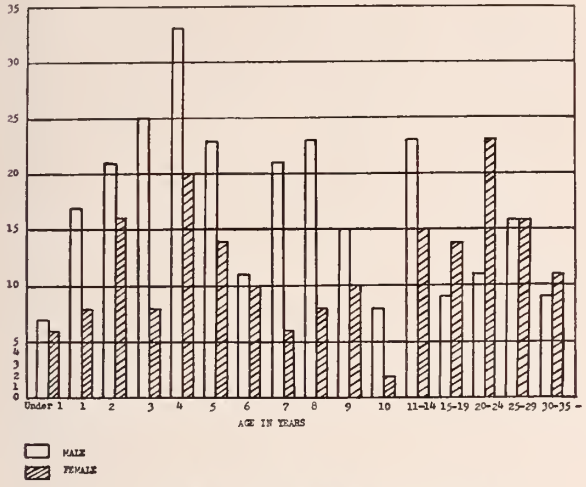

Chart 2.—Age-sex correlation of the 1951 poliomyelitis cases.

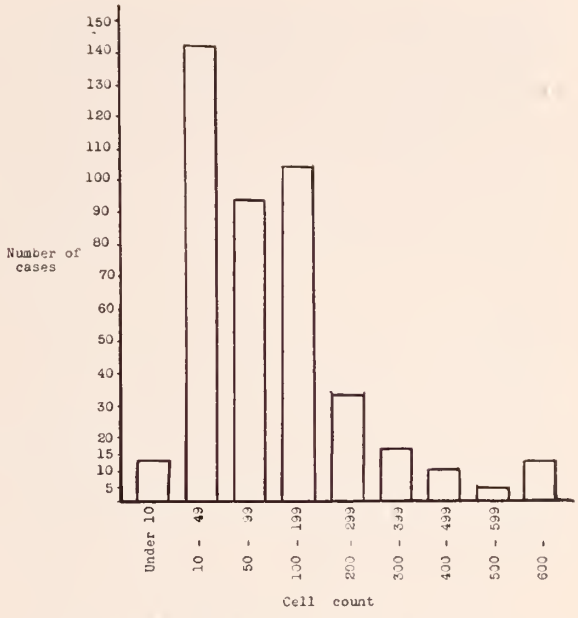

Chart 3.—Initial spinal fluid cell count.

Chart 3 presents the cerebrospinal fluid cell counts. It is evident that 79 per cent of the presented cases had between 10 and 200 cells per cubic mm., and there was a preponderance of lymphocytes. There were several frank poliomyelitis cases in which no cells could be found in the cerebrospinal fluid.

In a clinical classification of our 459 cases, 198 were non-paralytic, 186 were spinal paralytic, and 75 were bulbar and spinal-bulbar types. The 31 deaths in this series occurred in the bulbar and spinal-bulbar types. The bulbar types were classified in accordance with Baker's suggestion with slight modification.

Bulbar Poliomyelitis

1. Encephalitic
   - A. Focal
   - B. Diffuse
2. Cranial nerve nuclei involvement
   - A. The upper cranial nerve nuclei
   - B. The lower cranial nerve nuclei
3. Olivary level (or what is called "autonomic nerve depot" area)
   - A. The vascular type
   - B. The respiratory type
4. Spinal-bulbar
   - A. Lumbar bulbar ascending
   - B. Thoraco-cervical bulbar ascending

The 75 bulbar cases represent 15.9 per cent of the total. This is less than the 22.2 per cent noted here from 1940 up to the time of the present study. The 1951 bulbar cases were older in age than the non-bulbar cases and there was a slightly higher percentage of males. Fifty-three per cent of the bulbar patients were under 11 years of age and 70 per cent of the non-bulbar group were under 11 years of age. Sixty-three per cent of the bulbar group and 58.8 per cent of the nonbulbar group were male. There was no diagnostic feature of the cerebrospinal fluid examination which would have been helpful in differentiating the bulbar and the non-bulbar groups. Twenty-five cases were the upper bulbar forms and 50 were of the spinal-bulbar type. In the bulbar group 13 deaths occurred, for a percentage of 42 per cent, while 18 deaths occurred in the spinal-bulbar form with a percentage of 58 per cent. The bulbar death rate was higher than the average of 32 per cent for the last 12 years. Of our bulbar cases, 1 was a diffuse encephalitis, 1 a focal encephalitis, 5 involved predominantly the autonomic nerve centers, 2 the respiratory center, and 3 the circulatory center.

In those cases with involvement of the cranial nerves, 4 had upper cranial nerve involvement and 14 had lower cranial nerve involvement. Fifty of the cases were spinal-bulbar in character. The 5 cases involving the autonomic nerve centers were fatal, as were 8 cases involving the lower nerve nuclei. Eighteen, or 36 per cent of the spinal bulbar patients expired. It is quite evident that there is overlapping in a classification of these cases, but the most pronounced clinical observations had been accepted as a basis for the classification. The most commonly involved cranial nerve nucleus in this group was the tenth; although actually nerve nine, ten, and eleven may be correlated together as one group. The demonstration of involvement of the vagus nerve was evident by the nasal twang, regurgitation of fluids through the nose, puddling of fluids in the hypopharynx, and the absence of a cough reflex. Gastric upset was found to accompany this particular syndrome. Of all the bulbar cases, 61.4 per cent showed evidence of involvement of the tenth nerve. Seventh nerve involvement was next in frequency, being observed in 26 or 34 per cent of the cases. Signs of encephalitis were noted in 7 cases or 9.3 per cent, while circulatory embarrass-

ment was noted in 5 cases or 6.7 per cent, and respiratory failure in 11 cases or 14.7 percent.

Although 23.6 per cent (108 cases) were less than four years of age, chart 4 reveals that only 3.2 per cent of the total deaths fell in this age group. In the ages between four and twelve, 44.3 per cent or 203 cases of the total had 43 per cent of the deaths. As can be noted, the 20 year and above age group had the largest percentage of deaths, 38.7 per cent in only 18.7 per cent of the total cases. It was noted that 68 per cent of the fatal cases in the 1951 epidemic were male, although study of the total cases in the 11 year period from 1940 through 1950 reveals that only 54 per cent were male.

Of the total number of cases in the 1951 series there were 53 women in the child-bearing age. There were 44 married women and 30 per cent of these were pregnant. This figure of 30 per cent is much closer to the national average (25 per cent) than the 57 per cent we had been noting in Milwaukee for the last eight years.

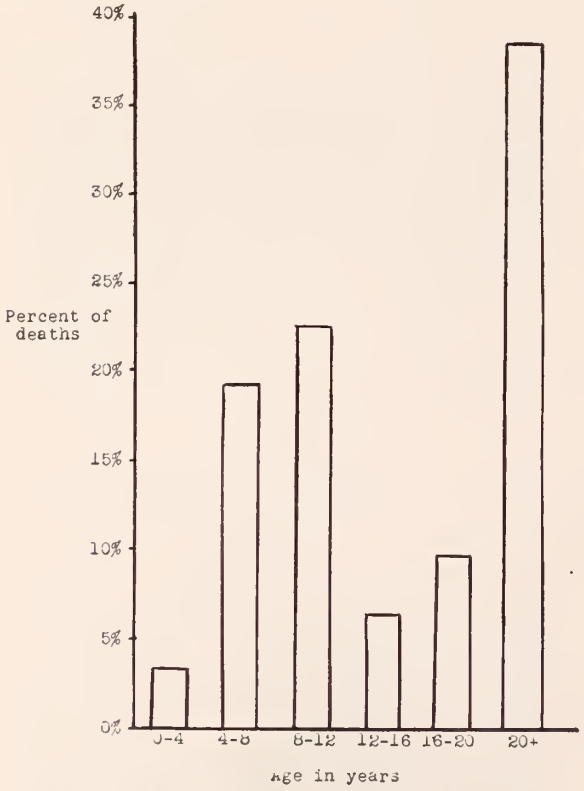

Chart 4.—Percent of deaths related to age in 1951.

Discussion

As had been seen in the previous 10 years, the outstanding features of 1951 became quite evident as the epidemic developed. Of all the facts produced, one salient feature presented itself. Whereas in the past we had been finding older age groups involved, the 1951 group was younger. In addition, the deaths occurred in a higher age group than they had previously. We observed that the cases were quite classical in that clinically the diagnosis was made much more easily. It was also true that the doctors were making much earlier, quicker, and better diagnoses of the non-paralytic cases. One of the outstanding features was the occurrence in families of multiple cases that were not staggered with intermittent incubation time, but on the contrary, when we would find others in addition to the child admitted to the hospital in the home, we could go back and check up and find unaccountable fever. In some cases we even noted evidence of a residual paralysis such as a foot drop or a weakness of the quadriceps of a leg. This was true in one family of seven children. We had four of one family in the hospital, and we know that the fifth one was at home and also sick, with a diagnosis of "summer flu." What we did notice in multiple cases was that when there was only one child in the family, oftentimes the father or mother was brought in with the child, or that in going back into other homes, the father or mother had been sick. Multiple cases were more evident this year.

On comparing our records for the year of 1947 we noted that of 87 cases in our community not a single transfer to a private hospital was necessitated, nor were any residual cases observed with the exception of an 18 month old child who was sent to us from Germantown with paralysis of the right deltoid. This is important because of the interlocking of our thoughts with the County Medical Society. As of now we are hailing this typhoid-like treatment of this disease from the starting point, *i.e.* from common portals of entrance, uncommon portals of entrance, and the accepted dictum that elective surgery in children and especially under the age of 16 be postponed. The policy of the County Medical Society in avoiding adenoid-tonsillectomy, herniotomy, and dentitional corrections during a poliomyelitis epidemic is a step forward and is in accordance with the general policy of students of infantile paralysis. Perhaps the time will come when we will be able to progress a little further. Our present study is still in the preliminary state, and it is impossible to indicate whether active immunization should be exercised.

A new work has just been revealed on viral-hemoagglutination. It may be that when a virus laboratory is set up with viral-hemoagglutination (as first brought out by Hurst in 1941 and modified by Forman's present work), that strain identification may be established early instead of waiting as we did this year, knowing that there was an epidemic in a girl's camp up north where 20 of the girls' swabs revealed a Coxsackie infection. Perhaps that is what we had in 1947, and in the future we will be in a position to stop elective surgery during the heights of the disease when we are confronted with positive diagnosis. The viral-hemoagglutination is not a replacement; it is really an interference with what we call adaptation to the human kind and will not permit the introduction of another virus. It is too bad some men are introducing various in-

fections deliberately in children to postpone the disease. I cannot agree with the practice started in Texas of rabies vaccination in order to ward off invasion of the poliomyelitis virus. This method of replacement or occupancy of cells in a given season is just a deliberate delay for a period of time until an epidemic assumes such drastic proportions, as it did in 1949, 1950 and especially in 1951. It is a well understood fact that for every recognized case there may be 150 to 300 unrecognized on the outside. Interpretations from neutralization studies are that these individuals do develop an active immunity, not by silent contact, but by having had the disease. If, on the other hand, it is exercised in that particular season and an agglutination does not show cross-agglutination, it is not an immutable antibody. This new viral-hemoagglutination is going to be a very significant work, and it will be introduced as part of the practical approach in our virus laboratory.

Summary

1. There were 512 cases of poliomyelitis admitted to South View Hospital from Milwaukee and the Milwaukee area in 1951. The first 459 cases admitted to the Isolation Hospital are statistically interpreted, and compared with outbreaks of previous years.

2. Cases were admitted every month throughout the year, with the peak incidence in August.

3. As the epidemic progressed it was noted that there was an increase over former years in cases in the 0 to 5 year age group and 20 years and above age group, with a decline in the number of cases in the 11 to 15 year age group. The bulbar and spinal-bulbar patients were older than the non-bulbar patients.

4. More males (65 per cent) were affected in the 0 to 15 year age group, but in the above 15 year age group, the majority (58.7 per cent) of the patients were female. Including all ages, there was a 6.6 per cent increase in the male poliomyelitis patients as compared with previous years.

5. Of the 459 cases, 198 were nonparalytic, 106 were spinal paralytic, and the remaining 75 consisted of bulbar and spinal-bulbar cases.

6. There was a 6.3 per cent decrease in the number of bulbar and spinal-bulbar cases over previous years.

7. The mortality rate was 6.8 per cent, and 68 per cent of the fatal cases were males. All of the deaths occurred in the bulbar and spinal-bulbar cases. The 20 year and above age group had the greater percentage of deaths, and the least percentage of deaths occurred in the 0 to 4 year age group.

8. Of the female patients, 30 per cent of the married women in the child-bearing age were pregnant, a percentage more closely approximating the national average than the 57 per cent we had noted in Milwaukee for the previous eight years.

9. The cerebrospinal fluid examination revealed the characteristic predominance of lymphocytes in the poliomyelitis victims, with cell counts varying between 0 to 200. Several frank clinical cases had no cells.

10. A classification of bulbar poliomyelitis is presented and the type of neurologic involvement of our bulbar cases is cited.

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1952 ESSAY CONTEST ANNOUNCED BY AMERICAN SOCIETY OF PLASTIC AND RECONSTRUCTIVE SURGERY

The Foundation of the American Society of Plastic and Reconstructive Surgery offers awards in junior and senior classifications for original contributions in this field.

Junior Classification: Two six month scholarships in leading plastic surgery services in the United States, England, and Italy will be awarded.

Senior Classification: The Foundation's annual prize, a silver plaque, will be given for the best essay presented at the annual meeting of the Foundation.

The contest is restricted to residents and surgeons in the practice of plastic and reparative surgery for not longer than five years. The subject matter of the essay should be the result of some original clinical or laboratory research in plastic surgery of recent date. All essays should be submitted in quadruplet form in English with no indication of the writer's name or his institutional affiliation, but should be identified by a legend. This legend should appear on the outside of a sealed envelope which contains the name, address, and affiliations of the contestant.

All entries must be received by the award committee not later than September 1, 1952. Further inquiries should be addressed to: The Award Committee, % Jacques W. Maliniac, M. D., 11 East 68th Street, New York 21, New York.

Paget's Disease of Bone (Osteitis Deformans)

Report of a Case Treated with Cortisone

By VICTOR S. FALK, JR., M. D., F. A. C. S.
Edgerton

ONE century ago, in 1852, Sir James Paget observed his first patient with a condition which he called osteitis deformans and which subsequently has been named Paget's disease of bone. His classic description of this disease published in 1877[1] has not been improved upon in the succeeding years. Unfortunately the same has been true of our knowledge as to its etiology and treatment. Although the literature on the subject is voluminous—914 papers published by 1951—the theories on pathogenesis and therapy have been numerous and short-lived.

The purpose of this paper is to briefly summarize the disease osteitis deformans and to present a far advanced case which responded favorably to treatment with cortisone acetate administered orally.

Etiologically much can be stated only in a negative way. Paget's disease of bone is neither infectious nor neoplastic; hence, the term osteitis deformans is a misnomer. Geographic, climatic, racial, dietary, and endocrine factors do not seem to play a part. The incidence in males is slightly greater than in females. The average age of onset is about 50, with most cases occurring in the fourth, fifth, and sixth decades and very rarely under the age of 30. Schmorl[2] concluded from his necropsy studies, especially of the vertebrae, that the incidence of Paget's disease in people past 40 is about 3 per cent. However, clinically manifested Paget's disease is much less common. There has been some familial tendency. (In Dickson's[3] series 16 patients had 21 relatives with Paget's disease, and Crumpacker[4] reported 3 siblings having the same condition.) Except for degenerative changes and postmenopausal osteoporosis, Paget's disease is probably the most common non-neoplastic disease of the adult skeleton. Since the advent of the roentgen ray, many more cases of Paget's disease have been discovered, many of them simply incidental findings on other radiologic studies. Prior to x-rays, the diagnosis was based on advanced deformities.

Pathologically the bones in Paget's disease increase in thickness and length. The bone is more vascular, more porous, and softer. The distinction between compact and spongy bone is lost. Necrotic and ultimately cystic areas appear. According to Schmorl,[2] the earliest microscopic change to be observed is the appearance of osteoclasts which hollow out and remove normal bone. As the bone is removed, both it and the intervening marrow are replaced by a well formed fibrous tissue without exudation or inflammatory cell infiltration. While some bony trabeculae are being removed by the osteoclasts, new ones are being laid down by osteoblasts. This new bone exhibits alternate denser and less dense layers giving a mosaic like structure similiar to the cross section of a tree trunk. This was first described by Schmorl and is regarded by him as characteristic of Paget's disease. Subsequently, local necrosis of bone occurs followed by liquefaction and formation of cysts.

Biochemically, the blood studies are quite constant. Serum calcium and phosphorus levels are within normal limits, and the serum alkaline phosphatase is usually increased.

The symptoms are variable from none to legion. Pain in the region of bone involvement is most common. Headache, backache, deafness, decreased vision, a crouching posture, bowing of the femora, enlargement of the skull, fatigability, and general muscle weakness have all been frequently noted. The pelvis, femur, skull, tibia, vertebrae, clavicle, humerus, and ribs are affected in that order of descending frequency.

The two most common complications are pathologic fracture and sarcoma. Lake[5] reported 24 per cent of the cases in his series of Paget's disease were admitted for fractures. At the Mayo Clinic[3] there were 77 fractures in 367 admissions for Paget's disease. Lake also collected a series of 102 reported cases of sarcoma complicating Paget's disease, but there are undoubtedly many unreported. Other complications include urinary and biliary calculi, psychosis, paraplegia, and cardiac failure. High pulse pressure (over 60 mm.), systolic murmurs, and cardiac enlargement are believed due to the tremendous increase in cardiac output. Cardiac catheterization[6] of a patient with generalized Paget's disease showed a cardiac output of 13.3 liters per minute, or about three times the normal average. This is in turn believed due to the great increase in blood flow through the involved bones. Other studies of bone blood flow, in a case where only one tibia was affected by Paget's disease, showed the flow to be five to seven times as high as in the normal leg. This highly vascular state of Pagetic bone has also been noted in that the skin temperature over the affected bone is higher than normal.

The prognosis as to life is good, the complications usually determining the course. Sarcoma is rapidly and uniformly fatal. Spinal cord compression and cardiovascular complications are also unfavorable.

Treatment has for the most part been symptomatic and palliative. This would include x-ray therapy for the relief of bone pain and orthopedic correction of deformities. The literature is filled with reports of past treatments, most of them apparently now in discard. High calcium and high

Fig. 1.—Anteroposterior view of skull showing advanced Pagetic changes.

Fig. 2.—Lateral view of skull. White markers indicate periphery of outer table of bone. (Circumference of skull 72 cm.)

vitamin D diets were once recommended, but are now believed contraindicated because of renal calculus formation. The theory that aluminum acetate inhibited the absorption of phosphates by forming insoluble aluminum phosphates has not been proved. Berman[7] found a lowering of serum phosphatase and subjective improvement with adrenal cortical extracts. Synthetic estrogens, cobra venom, and parathyroidectomy have also been suggested in treatment. Since spontaneous remission of pain and arrest of the process can occur, this must be borne in mind in evaluating any treatment. There have been no reports in the literature of the use of cortisone in the treatment or palliation of Paget's disease.

Report of a Case

This 64 year old male first had symptoms referable to the skeletal system about 30 years ago. Beginning at that time he had generalized aching upon awakening every morning and after every nap, so intense that he felt as if his "arms and legs would break off if they were moved." The first deformity was noted in 1935 when one clavicle developed a marked bulge. The diagnosis of osteitis deformans was made in 1939 when x-rays of the skull, pelvis, and femora disclosed the typical Pagetic process. The first treatment consisted of calcium and vitamin D. Adrenal cortex was next used and seemed to arrest the disease for about two years. Aluminum acetate was administered without benefit. The disease progressed slowly until January 1948, when the patient sustained a complete pathologic fracture of the right femur when he sat down twisting his thigh under him. It was at this time that the writer first attended the patient. The fracture was treated with skeletal traction for 12 weeks and eventually healed. Six months after the injury the patient was able to get about in a walker.

Late in 1948 low abdominal pain was the predominant complaint. A barium enema study revealed a normal colon, but advanced Paget's disease of the spine with partial collapse of the first lumbar vertebra. X-rays a month later showed evidence of compression of the first and third lumbar vertebrae with a 50 per cent loss in height. This was believed to account for the nerve root pain. Bones of the pelvis and hips were enlarged, and there was cortical thickening. Bony trabeculae were coarse and thick and were interspersed with cystic areas. In 1949 there was noted decreased hearing and loss of equilibration; the frontal bosses rapidly became more prominent; and reading elicited headaches although a mild refractive error was corrected with lenses. X-ray therapy over both knees and the spine provided some temporary relief from pain.

Past Medical History:—The patient had had measles, mumps, and chickenpox in childhood, and an appendectomy in 1920. He had sustained an injury to his right knee in a fall in 1912. He had played college football with no particular injuries.

Social History:—The patient is married, the father of five normal children, and he had been a farm implement dealer his entire adult life. He has smoked cigars heavily since the age of 21, but has not used alcohol. He has always lived in southern Wisconsin.

Physical examination revealed a well nourished male with a markedly enlarged head. The skull measured 72 cm. at its greatest circumference. The

frontal bosses were prominent and supraorbital ridges were widely overhanging; there were numerous irregular elevations and depressions of the skull; and the occiput protruded in a sharp ridge. The posture was crouching or simian in attitude. The spine was shortened by kyphosis and scoliosis. The left femur was more bowed than the right because of the prolonged skeletal traction on the right used in treating the pathologic fracture. The clavicles were grossly enlarged.

Other pertinent physical findings were a blood pressure of 160 systolic and 86 diastolic; a blowing systolic murmur over the precordium, most intense at the apex; cardiac enlargement to the left; cardiac rate of 84, with an occasional extra systole; and generalized arteriosclerosis.

Laboratory findings included a negative Wassermann test; a hemoglobin of 75 per cent; a red blood corpuscle count of 4,410,000; and a white blood cell count of 9,050, with a normal differential picture. Serum calcium was 9.6 mg. per cent, serum phosphorus was 3.32 mg. per cent, and serum alkaline phosphatase was 15.1 King–Armstrong units.

Course:—Headaches became more prevalent in 1950. The use of the steroids in treating Paget's disease was barely touched upon in the literature, apparently as an afterthought to their use in osteoporosis. Consequently, the patient was given testosterone injections, 50 mg. each, two to three times a week. When a four plus albuminuria suddenly developed, the testosterone was discontinued. In April 1951, the headaches became much more severe. The skull became larger and more irregular in contour. Frequent nausea, occasional vomiting, severe photophobia, and emotional instability accompanied the headaches. Treatment with ergotamine tartrate was of no benefit; intravenous injections of hypertonic glucose solutions gave temporary relief; and codeine and morphine were used with increasing frequency and in larger dosage until we were dealing with virtual addiction. Frequently the pulse became weak, rapid, and thready, and the patient was bathed in a cold sweat. (An electrocardiogram showed marked changes compatible with arteriosclerotic disease.) The writer was obliged to see the patient two to three times daily, and two nurses were employed to attempt to cope with the headaches. Ice cold compresses and massage over the skull prominences afforded momentary easement.

Repeated neurologic, orthopedic, and radiologic consultations depleted all therapeutic suggestions. Inquiries as to the use of cortisone in the treatment of Paget's disease brought only the meager information that it was "contraindicated." However, the severity of the headaches had exhausted the patient, his family, and his physician. It was obvious that

Fig. 3.—X-ray of lumbosacral spine showing coarse trabeculation throughout. The sacro-iliac spaces are obliterated.

Fig. 4.—View of hip joint showing characteristic roentgenographic changes of Paget's disease.

the patient could not live more than a short time without some respite.

On Aug. 8, 1951, the patient was given one 25 mg. tablet of cortisone acetate at 6 p.m. and another at 10 p.m. He slept well all night and has not had a severe headache since that date (now almost six months.) He has continued taking one or two tablets daily, very rarely three in one day, except for a period of one week when he went without any cortisone. Since the introduction of cortisone, he has required no morphine and for more than three months took no codeine. Now he uses only an occasional codeine tablet (¼ to ½ grain.) One week after starting the cortisone, the patient began going to his office several times weekly, something he had been unable to do for many months. Other changes noted were improvement in walking, better hearing, and clearer mentation. The two nurses were dismissed, and the writer has seen the patient only because of his interest in the case and to observe the remarkable effect of cortisone. This result, although it may be purely palliation, is certainly not on the basis of euphoria alone.

Summary

Osteitis deformans or Paget's disease of bone is characterized by thickening, softening, and bowing of the bones of the extremities and enlargement of the bones of the skull. The etiology is unknown. The diagnosis is usually made with a roentgen picture of a roughened and thickened periosteal layer of bone, degenerative areas in the cortex, and obliteration of the marrow cavity. Treatment in the past has been variable and unsuccessful.

A long standing case of Paget's disease with severe headaches has been treated with small doses of cortisone acetate tablets for seven months. The immediate gratifying relief, especially of the headaches, seems worthy of reporting. The general physical and mental improvement far exceeds a simple cortisone induced euphoria. The apparent arrest of the disease is not believed to be a spontaneous remission since there had been unrelenting progress in recent years.

Conclusion:—The use of cortisone acetate in the treatment of advanced Paget's disease of bone seems justified on the basis of the dramatic symptomatic relief obtained even in this single case.

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DOCTOR DICKIE TO REPORT AT MISSISSIPPI VALLEY TRUDEAU CONFERENCE

Dr. Helen A. Dickie, associate professor of preventive medicine and clinical medicine at the University of Wisconsin Medical School, Madison, will be among physicians giving reports at the annual conference of the Mississippi Valley Trudeau Society at St. Louis in October.

Doctor Dickie will give a "Report on an Investigation of the Changes in Resected Lungs following Isoniazid Therapy" on Saturday, October 18. The Trudeau conference, which will be held October 17 and 18, is being conducted in conjunction with the annual conference of the Mississippi Valley Conference on Tuberculosis October 16–18 at the Jefferson Hotel in St. Louis.

Two Milwaukeeans, C. W. Kammeier, executive secretary of the Wisconsin Anti-Tuberculosis Association, and the Rev. A. H. Schmeuszer, superintendent of Evangelical Deaconess Hospital, are the only other Wisconsin persons on either program.

The Reverend Schmeuszer will participate October 16 in a public health session of the Conference on Tuberculosis. He will speak on routine admission X-raying for general hospitals. Mr. Kammeier will be chairman of a discussion group on October 17, on organization and administration in tuberculosis control work.

Mental Examination in Military Induction

By JOSEPH E. WEBER, M. D.
Milwaukee

DURING the last war we learned much about the proper selection of men for military service. One fact soon became evident, that those men who revealed difficulties in adjustment or broke down under circumstances of civilian life could be expected to do the same under the regimented stresses of military service. The psychiatrist must keep this in mind constantly as he interviews each man. It is perhaps the best evidence of emotional trouble, next to that revealed by symptom formation, apathy, compulsive traits, delusions or hallucinations.

The psychiatric examination at induction stations, at present, consists of a simple screening test which is given each man, and a psychiatric interview with each of the inductees who scores low on the test and with those who display emotional abnormalities during the medical examination. While much can be said about the value of a personal interview for each inductee, those of us who saw how it operated in the past are happy that the army has seen fit to use the screening test. The psychiatrist can err seriously if he is overburdened by too much work.

A number of significant syndromes are commonly encountered. They are as follows:

1. *Mental Deficiency.*—This is revealed by poor intellectual, social, and industrial capacity, and by limited educational attainment. Persons in this group may adjust satisfactorily in a simple society but tend to disintegrate rapidly when forced to compete with normal men.

During the induction period each man takes a qualification test which helps weed out the illiterates and the defectives. The test is conducted by army psychologists and is independent of the psychiatric interview.

2. *Inadequate Personality.*—Here there usually is little intellectual disturbance, but the inability to grow up and to assume adult responsibilities is apparent. Growth may be stunted in various ways. In this group are found the criminals, eccentrics, bums, racketeers, sexual deviants, drug addicts, and many others.

Typically, the neurotic person quits school in the seventh or eighth grade because he gets fed up with the routine. He then wanders around from one place to another not adjusting to any one job for more than a short time. He usually prefers seasonal or "shady" occupations. When he gets married, he tires of his wife and soon deserts her, but not until he has proved his virility. That he has two or three children makes no difference to him. His need for change eventually drives him to the recruiting station.

In the service his impulsive and thoughtless behavior again is manifest. He cannot tolerate idleness; he resents authority; leaves camp without permission, drinks, gambles, gets into various sexual difficulties, finally is apprehended, and ends up with a court martial sentence. He never profits from experience. His destiny is mapped out for him as though by fate. He repeats the same pattern because of the attention he receives on one hand and the punishment he obtains on the other. The almost irreversible nature of this syndrome presents a tremendous problem both for civilian and military authorities. Police officials sometimes urge these men to get into the armed services, to relieve the community of the responsibility rather than to help the man.

3. *The psychoneuroses.*—These conflict-ridden individuals develop protective devices which spare them the necessity of adequately coping with reality. They may be full of fears, emotionally depressed, abnormally preoccupied with their visceral sensations, or may display abusive, compulsive, and hysterical behavior. Conformity and achievement continually clash with hostile, aggressive and sexual impulses.

This struggle produces a variable amount of emotional tension. The energy thus produced is often converted into patterns of behavior or symptoms for the sake of economy. It is often easier to deny conflicts and give in to childish attitudes. The moods swing from guilt-ridden submissiveness to irritability and hostility. Because of the individuals immaturity he must repress his antagonisms and, to be accepted, he must act overtly obedient in his interpersonal relationships. He fears his own aggressiveness and fears what may happen to him if he should ever let go.

At home with the weaker members of the family, he may permit this infantile angry behavior to erupt, and this reinforces his unconscious fears and tends to strengthen his repressions. He succumbs to infantile autoerotic forms of gratification. He may bite his nails, wet his bed, day dream, masturbate, develop somatic complaints, or withdraw. He leads a dull and unimpressive existence, always partially inhibited, always fearful of his own instincts. Only in his dreams does he sometimes let go, but then in such a distorted manner that his satisfaction can only be on an unconscious level.

4. *Homosexuality.*—Except for the frank endocrine type, these individuals somehow or other have solved their anxiety by refusing to mature past the latent, homosexual stage of development. Conscious anxiety arises when heterosexuality is forced on

them or homosexuality is denied them. Usually they are creative, intellectual, refined people. They usually avoid vulgarity in any form; they prefer feminine pursuits, enjoy dancing, tennis, travelling, and good music. They may establish a pretense of masculinity in order to avoid detection. They have girl friends, get married, drive trucks, and work in factories.

History usually reveals maternal identification and overt hostility to the father. They can get along with the opposite sex on an intellectual or occupational plane only. They admit that women have no sexual appeal for them. This projected disgust really indicates the unconscious contempt they have for themselves. They might put it this way, "I'm no good because I'm not like my father, just like you are not like him because you are a girl." The diagnosis is usually apparent. They readily reveal their fixation by their manner of speaking, interests, clothes, and occupation. Frequently identification with weak subversive elements tend to involve them in unpatriotic and disloyal groups.

5. *Psychosis.*—The incipient and post-psychotic states are most often seen. The most significant finding is an admission of ideas of reference by an emotionally dull, apathetic individual. Often religious interests preoccupy him. He avoids group participation, feels rejected by his own sex, and tends to shun the opposite sex. The frankly psychotic man is under constant pressure of his delusions and hallucinations; his responses are inappropriate and often silly.

Occasionally early paranoia is seen. This condition is found in individuals who appear to function and socialize fairly well. However, they tend to entertain certain illogical and irrational ideas in regard to one or more individuals or organizations. The complex which lies at the bottom of these thoughts is highly charged with energy and produces systematized and expansive ideas of great force and intensity. Ideas of persecution, infidelity, and poisoning are common.

6. *Enuresis.*—This is often a puzzling symptom especially as it occurs in adults who appear fairly well integrated. Nocturnal bed wetting without diurnal wetting is almost always psychogenic. The dynamics are not understood. Where it persists from childhood, with or without remissions, it may mean a persistent clinging to infantile satisfactions.

7. *Malingering.*—Malingering, or conscious simulation of a disease condition, while not common does occur. Often military service means much personal sacrifice. Where individuals are reluctant to give up certain achievement values or certain secure and promising positions of civilian life, they may seek varied and devious means of avoiding military service. This situation may be compared to compensation litigation where counseling and coaching is often the rule rather than the exception. Because literature concerning the various nervous and mental syndromes is available to the layman and because objective findings can not be relied upon as the sole criteria for diagnosis as is the case in other branches of medicine, feigned illness is always a possibility and very careful evaluation is necessary.

The diagnosis of mental and nervous disorders conforms to the American Psychiatric Association classification. Two broad groups are recognized—the reaction types and the personality disturbances. The reaction group includes the two ideopathic psychoses, schizophrenic and manic depressive, as well as all the psychoneurotic and psychosomatic syndromes. The personality disturbances comprise the psychopathic states and include schizoid personality, paranoid personality, inadequate personality, and others. The value of this classification lies in the illumination it gives to the old medical terms "psychoneurosis," "psychosis," and "psychopathy." For example, the old diagnosis of "psychoneurosis hysteria" is now covered by the term "conversion reaction" and "psychoneurosis anxiety hysteria" by the term "phobic reaction."

Diagnosis continues to be based entirely on mature clinical judgment. The various accepted psychologic tests, such as Rorschach and the thematic apperception tests, are projective tests and are of little value in large scale induction examinations. Final evaluation and disposition must be based on what the individual says, feels, and does during the interview.

Occasionally, brief projective questions are of value after the more direct questioning has been concluded. The patient may be asked, "Are you concerned about your thoughts, feelings, or moods? Can you control your wishes or desires? What makes you happy? Have you ever felt like blowing your top? What are the worst things that could happen to any one? In your travels have you met any homosexuals? What would you do with your time if you had only six months to live?" Such questions may open new avenues of inquiry and may lead to the discovery of personality trends not suspected or revealed during the ordinary course of the examination.

Summary

Several common psychiatric syndromes frequently encountered in military induction are discussed. This is followed by a short outline of modern psychiatric terminology and a brief projective test which may be of value in rounding out the examination.

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2. Adorno, T. W., and others: The Authoritarian Personality. New York, Harper, 1950.
3. Campbell, J. D.: Psychiatry and mobilization, J.A.M.A. 146:87–93 (May 12) 1951.
4. Griffin, J.D.M., McKerracher, D. G., and Lawson, F. S.: Psychiatry in the Canadian Army, Am. J. Psychiat. 100:137–141 (July) 1943.

Wisconsin Anesthesia Study Commission of the Wisconsin Society of Anesthesiologists

Editor—DOROTHY W. BETLACH, M. D., Madison, Wisconsin

Complications of Spinal Anesthesia

THE RELATIVE simplicity with which spinal anesthesia may be administered has frequently resulted in its indiscriminate use. Many surgeons and anesthetists are unaware of or do not appreciate the hazards which exist. Among the serious complications is respiratory depression. The degree of intercostal paralysis increases proportionately with higher levels of anesthesia. Partial or complete circulatory collapse is also quite common. Unrecognized and untreated these disturbances may result in irreversible changes with the occurrence of fatalities.[1] Neurologic complications which frequently are not observed until the post surgical and convalescent periods occur in 0.01 to 0.5 per cent of all spinal anesthetics.[2] Arachnoiditis, meningitis, neuritis, myelitis, and cauda equina syndrome are the most serious sequelae.

The Wisconsin Anesthesia Study Commission presents a case illustrating the toxic and destructive effect of drugs on nervous tissue.

Report of Case

CASE 38.—A 28 year old white female was received on the obstetric service for treatment of a renal calculus complicating a seven month pregnancy. Her prenatal course had been uneventful and, except for a mild anemia, she appeared to be in good general condition although she was apprehensive and excitable. Ureteral catheterization was proposed. Premedication of 10 mg. of morphine sulfate and 180 mg. of nembutal were given and she appeared well sedated. Ten milligrams of 1 per cent pontocaine were injected intrathecally at the level of the L2–L3 space without difficulty while the patient was in the right lateral position. The ampule of pontocaine was examined carefully for breaks and contamination. Immediately after the injection, she was placed in lithotomy position and prepared for cystoscopic examination. The anesthetist had difficulty determining a definite anesthetic level because the patient was so drowsy. As soon as the cystoscope was inserted, the patient complained of a severe burning sensation over the entire abdominal area below the umbilicus and became hysterical. This was interpreted as apprehension and inadequate anesthesia. She was anesthetized with 500 mg. of 2½ per cent sodium pentothal solution given intravenously and cystoscopy with ureteral catheterization was easily accomplished.

When she was returned to her room, she was beginning to respond. Approximately one and one-half hours had elapsed since the spinal puncture. Blood pressure was recorded at 70/50 and within 15 minutes the pressure was imperceptible and her pulse was extremely weak and thready. The foot of the bed was elevated and intravenous fluids started. Five minutes later she became cyanotic and ceased breathing. Artificial respiration was started immediately, and 10 minutes later oxygen was administered under positive pressure by manual compression of an anesthetic bag and mask. There was no attempt by the patient to resume spontaneous respiration, and after one-half hour she was placed in a Drinker mechanical respirator. At that time she responded with grimaces when a nasal oxygen catheter was inserted, and she sneezed several times, but there were no other changes in her semicomatose state. Small doses of methadrine were given to sustain systolic blood pressure levels above 80 mm. of mercury.

The coma and respiratory paralysis continued. Twenty-four hours later a spinal puncture was done with the patient still in the respirator. The spinal fluid was bloody and contained many cells. On the second postoperative day, the patient was delivered of a stillborn macerated fetus. The next morning she started spontaneous respiration and was allowed out of the respirator for short intervals. Her condition became worse again and she died the following day, 96 hours after the spinal anesthesia had been administered. Autopsy was performed and the brain and entire spinal cord were removed. The lumbar area of the cord was completely necrotic. Patchy hemorrhagic areas extending to the level of the tenth dorsal segment were noted, and the cord was edematous and soft as high as the fourth cervical segment.

Comment

The patient's complaint of a severe burning sensation was the first indication that all was not well. By that time there was little which could have been done to prevent the tragic outcome. Immediate spinal tap with withdrawal of all of the spinal fluid and replacement with saline might have prevented death but not all of the cord destruction. Dilution and diffusion occur rapidly with introduction of the agent into the spinal canal but probably not before considerable absorption and fixation of the drug have taken place near the site of injection. Nerves in the lumbar area are in contact with the full concentration of the drug almost instantane-

ously. For an average sized woman, 10 mg. of pontocaine is not usually an overdose of drug. However, there is a growing realization that "average" doses are overdoses for many individuals. Statistically, there is increased sensitivity and danger to spinal anesthesia in pregnancy, and in this particular patient the amount of pontocaine administered constituted an overdose resulting in cord destruction and death.[3]

Anesthesia should not be used as a routine procedure. Spinal anesthesia is contraindicated in patients with known cord disease, infections and severe toxemias, herniated intravertebral disks, marked obesity, severe hypertension, or shock. Individuals with large abdominal tumors, including pregnancies, require smaller doses of drug and may develop sudden, irreversible shock with the sudden release of increased intra-abdominal pressure. Patients with intestinal obstruction must be protected from the danger of aspiration of intestinal contents which may pour into the pharynx as a result of the increased tone of the intestinal tract.

Constant care and observation of the anesthetized patient by a medically trained individual is essential. Adequate facilities for prevention and correction of untoward conditions should be available immediately. These include oxygen, means for assisting or performing artificial respiration, intravenous fluids and blood, sympathomimetic drugs such as neosynephrine or methadrine, and suction. Respiratory stimulants are not dependable and particularly should not be used when respiratory depression is due to intercostal paralysis from a high level of spinal anesthesia. All apparatus and drugs used must be completely sterile. It is wise to sterilize drug ampules in nonirritating highly colored solutions thus enabling detection of small breaks in the glass which allow for contamination. Turbid solutions of drugs should be discarded. The routine rinsing of syringes with sterile saline helps prevent introduction of foreign toxic substances intrathecally.

Only full appreciation and realization of the dangers of spinal anesthesia with careful evaluation and cautious administration can diminish the incidence of serious sequelae and unnecessary anesthetic deaths.

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1. Eversole, U. H.: Complications of Spinal Anesthesia, Surgical Clinics of North America 30:693–703 (June) 1950.
2. Kennedy, F., Effron, A. S., and Perry, G.: Grave spinal cord paralyses caused by spinal anesthesia, Surg., Gynec. and Obst. 91:385–398 (Oct.) 1950.
3. Lock, F. R., and Mason, L. B.: Obstetric deaths related to anesthesia, Report of 15 cases, New Orleans M. and S. J. 102:449–453 (March) 1950.

POSTGRADUATE CLINIC ON HEART DISEASE ANNOUNCED

Dr. Ovid O. Meyer, chairman of the postgraduate education committee of the Wisconsin Heart Association, announces a postgraduate clinic on heart disease for Wisconsin doctors.

The Faculty: Paul D. White, M. D., Consultant in Medicine, Massachusetts General Hospital, Boston, Mass.; Executive Director, The National Advisory Heart Council.
Alfred Blaloch, M. D., Professor of Surgery and Director of the Department of Surgery, Johns Hopkins University School of Medicine, and Surgeon in Chief, Johns Hopkins Hospital, Baltimore, Maryland.

The Time: Clinics will be held at the Marquette University School of Medicine in Milwaukee on Wednesday, October 22, and at the University of Wisconsin Medical School Auditorium in Madison on Thursday, October 23.

Description: Doctors White and Blaloch will conduct clinics in the afternoon on subjects furnished to them at the two medical schools. Each will give a formal presentation in the evening.
The title of Doctor White's talk in Milwaukee will be "Coronary Heart Disease," and his topic in Madison will be "Hypertensive Heart Disease." The doctor will also address the Milwaukee Academy of Medicine on October 21. He has chosen "Three Medical Eras" as his subject for this occasion.

The title of Doctor Blaloch's presentation will be "The Surgical Treatment of Certain Types of Cardiovascular Disorders."

These clinics are made possible through a special grant from the Wisconsin Heart Association and no fee will be charged. All members of the medical profession in Wisconsin are welcome.

Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

Notes on the Question of Drug Toxicities

The recent outburst of excitement regarding the appearance of toxic reactions to chloramphenicol (chloromycetin) has a familiar ring to one who has witnessed the development and introduction of a good many new and valuable drugs.

In regard to aplastic anemia and to other blood dyscrasias, we have abundant evidence of the dangers of benzene itself and certain of its derivatives. Some of the derivatives such as pyramidon, antipyrine, acetanilid, or acetophenetidin are known to have produced similar aplasias, yet they are essentially freely available to anyone. Acetylsalicylic acid and other salicylates are manufactured by the ton and are being used in spite of known, but rather rarely occurring, calamities resulting from "overdosage." We are more or less accustomed to these, but when a new and potent remedy has an occasional, or even rare, untoward aftermath, it constitutes news.

Sensitivity or tolerance is a matter of relativity. Not only is sensitivity to be recognized in the realm of drugs, but one knows of people who are sensitive to strawberries, foods made from wheat flour, certain fungi, mercury, mosquito bites, bee stings, etc., etc. It is well within the memory of most of us that reactions to the sulfonamides were being reported. Reactions to penicillin are frequently observed, but fortunately these are rarely fatal. It could be suggested that the reactions to the antibiotics are unique, but are they so strange after all? Every surgical operation has its operative risk, including the risk due to the general, local, or spinal anesthetic. The story is told that when Doctor Simpson of Edinburgh was about to use chloroform for the first time as a surgical anesthetic, he rubbed his finger along the proposed line of incision, when the patient promptly died. This death could scarcely have been ascribed to the toxic effects of the drug but rather to the finger-tip of the surgeon! However, deaths have been caused by the anesthetics, including nitrous oxide, ether, chloroform, ethylene, and cyclopropane. Squill, the bulb of a common early spring garden flower, contains a digitaloid glucoside which is toxic to neighborhood rats, etc., if fed to them. The green skin of a potato tuber which has been exposed to daylight while growing contains a very toxic alkaloid, solanine. The kernels of certain seeds or nuts contain glucosides which possess cyanide radicles which are potentially dangerous. Each summer has its crop of mushrooms, some species of which are poisonous.

Any chemical capable of modifying the activity of cells in the living body, be it stimulation or depression, can produce dire results if absorbed in excessive amounts. Even a Thanksgiving turkey dinner has been known to be harmful when "administered" in quantities beyond sound reason or established "dosages."

We are all more or less accustomed to employ insecticides for our flowering plants, for fruit trees in blossom, and for various crops. These substances kill insects—which are made up of protoplasm, as are we all. Certain animals are more resistant towards noxious agents than are others—and relative quantity makes a difference.

In the field of therapeutics, as stated above, an occasional patient or person may be "allergic" or may become unusually sensitive towards some chemical. The susceptibility of people towards poison ivy varies greatly; the sensitive ones respond to the most minute quantities, whereas the so-called resistant people can tolerate much more, and occasionally brazenly expose themselves to suffer very severe poisoning.

Therefore, it is not strange that an occasional accident occurs in clinical practice of medicine, and to practice "medicine" without the use of drugs may be dangerous by default. A minimum of danger can be attained by prior investigation of the patient's responses to the agents employed and by judging the dosages required by the responses produced. The writer has often said that to treat a patient requires knowledge and skill not far different from that required for diagnosis.— A. L. TATUM, M. D.

FOR YOUR INFORMATION

The Wisconsin State Board of Medical Examiners' office is now located in Oshkosh. All communications should be addressed to A. G. Koehler, M. D., Secretary, Wisconsin State Board of Medical Examiners, 46 Washington Boulevard, Oshkosh.

1952 Annual Meeting

MILWAUKEE—OCTOBER 6-7-8

■ W. S. BUMP, M. D.
Moderator, General Session

Scientific Programs for MONDAY, OCT. 6

9:00–10:00 A. M.: Small Group Teaching Programs

OBSTETRICS AND GYNECOLOGY — Stage of Exhibit Hall

TOXEMIAS OF PREGNANCY: Movie and discussion. Discussion conducted by Harold W. Shutter, M. D., Milwaukee.

FRACTURES AND APPLICATION OF CASTS—Stage of Exhibit Hall

Emphasis will be placed on fractures of the radius, lower end, and fractures of the ankle. Fractures of the shaft of the humerus will also be included. Demonstrations by members of the Wisconsin Orthopedic Society, under the direction of Joseph R. Stone, M. D., Milwaukee, and James Nellen, M. D., Green Bay.

X-RAY INTERPRETATIONS—Dressing Room East of Stage

SCOUT FILM OF THE ABDOMEN: Robert W. Byrne, M. D., Milwaukee
(Those attending are invited to bring with them interesting and significant x-rays for discussion.)

MANUAL ARTIFICIAL RESPIRATION — Foot of Stage

Each day members of the Wisconsin Society of Anesthesiology will conduct demonstrations, with the use of live patients, on the newest methods of artificial respiration. Robert R. Brazy, M. D., Veterans Administration Hospital, Wood, will serve as lecturer during the course of the demonstrations. In addition, the use of the anesthetic machine and a simple oxygen tank, bag, and mask, as well as special instruments used in resuscitation by the anesthesiologist will be featured as part of the demonstration.

(THIS WILL BE REPEATED MONDAY AND TUESDAY AFTERNOON, DURING THE RECESS PERIOD, IN ADDITION TO THE DAILY MORNING DEMONSTRATIONS)

Related Teaching Exhibits

ANATOMY: Dissections and discussion on "The Anatomy of the Abdominal Cavity:" U. of W. Anatomy Dept. Doctors O. V. Hibma and Otto Mortensen as demonstrators, at foot of stage.

GROSS TISSUE: The Wisconsin Society of Pathologists will again present interesting displays and discussions on pathologic material of special significance. Located near foot of stage.

EXHIBIT DEMONSTRATIONS: Several scientific and technical exhibits will have special demonstrations of a scientific character. See official program for details.

Monday, Oct. 6

10:15–11:30 A. M.: Hospital Staff Conferences

All conferences will feature actual patients for demonstration purposes, whenever possible. These teaching conferences have become a popular feature of the Annual Meeting, and your participation through attendance is invited.

1. PEDIATRIC CONFERENCE: Staff of Children's Hospital, Milwaukee

WALKER HALL, MILWAUKEE AUDITORIUM: James P. Conway, M. D., Milwaukee, Moderator

Arthritis in Children: Vernon Kores, M. D.
Nephrosis: W. S. Polacheck, M. D.
Encephalitis: P. S. Pierson, M. D.

2. DISEASES OF THE PANCREAS: Staff of Veterans' Hospital, Wood

(Excluding diabetes mellitus, per se)

NORTH JUNEAU HALL, MILWAUKEE AUDITORIUM: Maurice Hardgrove, M. D., Milwaukee, Moderator

Physiology of the Pancreas and Laboratory Aids of Value in Diagnosis of Pancreatic Diseases: Joseph M. Lubitz, M. D.

Roentgenologic Aspects of Pancreatic Disorders: Theodore J. Pfeffer, M. D.

Acute and Chronic Pancreatitis:
Medical Aspects: Bruno J. Peters, M. D.
Surgical Aspects: C. M. Schroeder, M. D.

Tumors of the Pancreas: Forrester Raine, M. D.

3. SURGICAL–MEDICAL CONFERENCE: Staff of Milwaukee County Hospital

SOUTH KILBOURN HALL, MILWAUKEE AUDITORIUM: Joseph King, M. D., Milwaukee, Moderator

The Immediate Care of Injuries of the Hand: Frederick Bunkfeldt, M. D.
Pyelitis of Pregnancy: George S. Kilkenny, M. D.
The Treatment of Congestive Heart Failure: J. Kenneth Karr, M. D.
Late Complications of a Gunshot Wound: Joseph J. Gramling, M. D.
Carcinoma of the Lung: Joseph W. Rastetter, M. D.
X-Ray Diagnosis of Intra-abdominal Calcifications: Jerome L. Marks, M. D.

ROUND TABLE LUNCHEONS—MONDAY, OCT. 6

All Luncheons at Hotel Schroeder

FOURTH FLOOR LOCATIONS:

1. Parlor A: **Resuscitation of Patients Who Die in the Operating Room:** Claude Beck, M. D., Cleveland (Warner Bump, M. D., Rhinelander, Chairman)
2. Parlor B: **Some Aspect of Portal Hypertension:** Jacob K. Berman, M. D., Indianapolis (E. R. Schmidt, M. D., Madison, Chairman)
3. Parlor C: **Newer Drugs and Their Uses:** W. S. Middleton, M. D., Madison
4. Parlor D: **Anticoagulate Therapy: Present Status and Recent Advances:** F. W. Madison, M. D., Milwaukee
5. Parlor E: **Application of Newer Drugs in the Treatment of Hematologic Disorders:** Tibor Greenwalt, M. D., Milwaukee
6. Parlor F: **Making Hospitalization Serve Its Purpose:** Leslie Osborn, M. D., Madison
7. Parlor H: **Industrial Eye Injuries:** John Hitz, M. D., Milwaukee
8. Parlor I: **Surgical Treatment of Prostatic Hypertrophy:** J. B. Wear, M. D., Madison

FIFTH FLOOR LOCATIONS:

9. Room 507: **Selection and Training of Interns and Residents:** John Hirschboeck, M. D., Milwaukee
10. Room 508: **Diagnostic Criteria and the Surgical Results of Mitral Stenosis:** Forester Raine, M. D., Milwaukee, and Nathan Grossman, M. D., Milwaukee
11. Pine Room: **General Prognostic Considerations of Psychotic and Neurotic Patients:** Annette C. Washburne, M. D., Madison

SPECIAL LUNCHEONS

12. East Room (Fifth Floor, immediately opposite Crystal Ballroom): **Legal Aspects of Medical Practice:** Chester C. Schneider, M. D., and Mr. Kenneth Grubb, Milwaukee. NOTE: Attendance at this will not be restricted, but advance reservations for the luncheon are required.
13. Parlor G (Fourth Floor): PAST PRESIDENT'S LUNCHEON: Open to past presidents and the incoming president of the State Society.

(USE BLANK ON PAGE 805—NAME 3 SELECTIONS, AS ATTENDANCE IS LIMITED)

NOTE: LUNCHEONS FILLED AT TIME OF PUBLICATION: 2, 3

Special Events

5:30 p. m.: ELECTION OF SECTION DELEGATES: Parlors A thru I, Hotel Schroeder

6:00 p. m.: WASHINGTON UNIVERSITY ALUMNI ASSOCIATION DINNER: University Club

6:30 p. m.: WOMEN'S MEDICAL ASSOCIATION DINNER AND PROGRAM: Mathew Keenan Health Center, 3200 N. 36th St., Milwaukee

6:30 p. m.: SECOND SESSION, HOUSE OF DELEGATES: East Room, Hotel Schroeder

8:30 p. m.: SMOKER AND PROFESSIONAL ENTERTAINMENT: Ballroom, Hotel Schroeder

Monday, Oct. 6

2:00 P.M.: General Scientific Session

JUNEAU HALL—MILWAUKEE AUDITORIUM

W. S. BUMP, M. D., Rhinelander, Moderator

BECK

OUT-OF-STATE GUEST SPEAKERS

CLAUDE S. BECK, M. D.
Professor of cardiovascular surgery, Western Reserve University, School of Medicine, Cleveland

JACOB K. BERMAN, M. D.
Associate professor of surgery, Indiana School of Medicine, Indianapolis

BERMAN

2:00 p. m.: OPERATION FOR CORONARY ARTERY DISEASE: Claude S. Beck, M. D., professor of cardiovascular surgery, Western Reserve University School of Medicine, Cleveland

(The Lucy Ann Droessel Memorial Lecture, Wisconsin Heart Association)

2:45 p. m.: ATROPHIC CIRRHOSIS: Jacob K. Berman, M. D., associate professor of surgery, Indiana School of Medicine, Indianapolis

3:15 p. m.: RECESS TO VISIT EXHIBITS
Demonstration on "Manual Artificial Respiration" to be repeated.

4:15 p. m.: PRACTICAL METHODS FOR THE DIAGNOSIS AND TREATMENT OF EMOTIONAL ILLNESS: Annette C. Washburne, M. D., professor of neuropsychiatry and preventive medicine, University of Wisconsin Medical School.

(The Theresa Lemberg Rogers Memorial Lecture)

4:35 p. m.: TREATMENT OF THYROTOXICOSIS WITH RADIOACTIVE IODINE: E. C. Albright, M. D., assistant professor of medicine, University of Wisconsin Medical School

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6:30 p. m.: HOUSE OF DELEGATES: East Room, Hotel Schroeder

8:30 p. m.: SMOKER AND PROFESSIONAL ENTERTAINMENT: Ballroom, Hotel Schroeder

10:30 p. m.: INFORMAL DANCE: Ballroom, Hotel Schroeder

■ T. O. NUZUM, M. D.
Moderator, General Session

Scientific Programs for TUESDAY, OCT. 7

9:00–10:00 A. M.: Small Group Teaching Programs

OBSTETRICS AND GYNECOLOGY — Stage of Exhibit Hall

MANUAL ROTATION IN THE MANAGEMENT OF OCCIPUT POSTERIOR AND OCCIPUT TRANSVERSE POSITIONS: Movie and manikin demonstration with F. J. Hofmeister, M. D., Milwaukee, as discussant.

FRACTURE DEMONSTRATION—Stage of Exhibit Hall

Same basic demonstration as on Monday (see Monday program for description).

X-RAY INTERPRETATIONS—Dressing Room East of Stage

X-RAY DIAGNOSIS OF FRACTURES: Hobart Wright, M. D., Milwaukee

(Those attending are invited to bring with them interesting and significant x-rays for discussion.)

MANUAL ARTIFICIAL RESPIRATION — Foot of Stage

Same as Monday demonstrations (see Monday program for description).

Related Teaching Exhibits

ANATOMY: Dissections and discussion on "The Anatomy of the Abdominal Cavity:" U. of W. Anatomy Dept. Doctors O. V. Hibma and Otto Mortensen as demonstrators, at foot of stage.

GROSS TISSUE: The Wisconsin Society of Pathologists will again present interesting displays and discussions on pathologic material of special significance. Located near foot of stage.

EXHIBIT DEMONSTRATIONS: Several scientific and technical exhibits will have special demonstrations of a scientific character. See official program for details.

Tuesday, Oct. 7

10:15–11:30 A. M.: Special Symposia — INTERNAL MEDICINE OBSTETRICS AND GYNECOLOGY

"DIAGNOSIS AND THERAPY OF INFECTIOUS DISEASES"

JUNEAU HALL MILWAUKEE AUDITORIUM

EINAR DANIELS, M. D., Milwaukee, Moderator

with

WENDALL HALL, M. D.: Clinical assistant professor of medicine, University of Minnesota Medical School

BURTON A. WAISBREN, M. D.: Clinical instructor of medicine, Marquette University School of Medicine

JOHN W. BROWN, M. D.: Professor of preventive medicine and director of department of student health, University of Wisconsin Medical School

HALL

THE ACUTE BACTERIAL DISEASES; Aspects of Everyday Importance: Doctor Waisbren (Therapeutic usefulness and drawbacks of antimicrobic agents employed singly or in combination)

Discussants: Doctors Hall and Brown

CHEMOTHERAPY OF TUBERCULOSIS AND BRUCELLOSIS: Doctor Hall

Discussants: Doctors Brown and Waisbren

OTHER INFECTIOUS DISEASES ENDEMIC IN WISCONSIN: Doctor Brown (Practical significance for humans of diseases common to other animals)

Discussants: Doctors Hall and Waisbren

GENERAL DISCUSSION AND QUESTIONS FROM THE AUDIENCE

"SPECIAL PROBLEMS IN OBSTETRICS AND GYNECOLOGY"

KILBOURN HALL MILWAUKEE AUDITORIUM

F. JACKSON STODDARD, M. D., Milwaukee, Moderator

THE USE OF THE SEX HORMONE PRODUCTS IN GENERAL PRACTICE: Allan C. Barnes, M. D., professor of obstetrics and gynecology, Ohio State Medical School, Columbus

PSYCHOSOMATIC ASPECTS OF STERILITY: Sprague H. Gardiner, M. D., assistant professor of obstetrics and gynecology, Indiana University School of Medicine, Indianapolis

MANAGEMENT OF BORDERLINE PELVIC CONTRACTIONS IN OBSTETRICS: D. N. Danforth, M. D., associate professor of obstetrics and gynecology, Northwestern University School of Medicine, Chicago

ROUND TABLE LUNCHEONS—TUESDAY, OCT. 7

At Hotel Schroeder Unless Otherwise Noted

FOURTH FLOOR LOCATIONS:

1. Parlor A: **Infectious Diseases with Particular Reference to Brucellosis:** Wendall Hall, M. D., Minneapolis (John Brown, M. D., Madison, Chairman)
2. Parlor B: **Disturbances of Menstruation:** Allan Barnes, M. D., Columbus, Ohio (William Hovis, M. D., Milwaukee, Chairman)
3. Parlor C: **Diabetes Mellitus:** Bruno Peters, M. D., and William Engstrom, M. D., Milwaukee
4. Parlor D: **Choice Among the Antibiotics:** Harry Beckman, M. D., Milwaukee
5. Parlor E: **Obstetrical Anesthesia:** Sprague Gardiner, M. D., Indianapolis (L. T. Servis, M. D., Milwaukee, Chairman)
6. Parlor F: **Diagnostic and Therapeutic Application of Radioactive Iodine:** E. C. Albright, M. D., Madison
7. Parlor G: **Management of Peripheral Arterial Diseases:** James E. Conley, M. D., Milwaukee
8. Parlor H: **Management of Alcoholism:** Fritz Kant, M. D., Madison

FIFTH FLOOR LOCATIONS:

9. Room 507: **Medical Problems of Air Transportation:** A. J. Herbolsheimer, M.D., Chicago (S. E. Gavin, M. D., Fond du Lac, Chairman)
   (Open to all MDs interested in aviation medicine, including CAA Examiners)
   (As part of program O. H. Comess, M. D., Chicago, will discuss "Air Transportation of Persons")
10. Room 508: **Better Business Practices in Doctors' Offices:** Mr. J. P. Revenaugh, Professional Business Management, Chicago (R. S. Baldwin, M. D., Marshfield, Chairman)
11. Pine Room: **Problems of the Newborn:** E. T. McEnery, M. D., Chicago (J. P. Conway, M. D., Milwaukee, Chairman)
12. Pere Marquette: "**Electrolyte Metabolism:** Paul R. Cannon, M. D., Chicago
    (This luncheon will be open to everyone up to 40 persons. Following the luncheon and discussion there will be a regular meeting of the Wisconsin Society of Pathologists)

SPECIAL LUNCHEON

13. Convalescent Home: SPECIAL LUNCHEON AND CLINICAL DISCUSSION ON "RHEUMATIC HEART DISEASE" (Limit 25): Ely Epstein, M. D., Chairman

(USE BLANK ON PAGE 805—NAME 3 SELECTIONS, AS ATTENDANCE IS LIMITED)

NOTE: LUNCHEONS FILLED AT TIME OF PUBLICATION: 2, 4, 10

Special Events

9:00 a. m.: THIRD MEETING OF HOUSE OF DELEGATES: East Room, Hotel Schroeder

12:00 noon: MARQUETTE ALUMNI LUNCHEON: Blatz Brewery Auditorium. Get complimentary tickets at Alumni Office, 1533 W. Wisconsin Ave.

5:30 p. m.: PRESIDENT'S RECEPTION (for those attending Annual Dinner): East Room, Hotel Schroeder

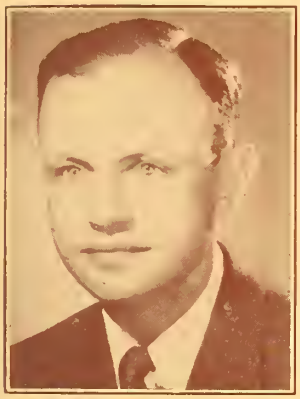
6:45 p. m.: ANNUAL DINNER: Ballroom, Hotel Schroeder

Tuesday, Oct. 7

2:00 P.M.: General Scientific Session

JUNEAU HALL—MILWAUKEE AUDITORIUM

T. O. NUZUM, M. D., Janesville, Moderator



BARNES

OUT-OF-STATE GUEST SPEAKERS

ALLAN C. BARNES, M. D.
Professor and chairman of department of obstetrics and gynecology, Ohio State University College of Medicine, Columbus

PAUL R. CANNON, M. D.
Professor and chairman of department of pathology, University of Chicago

OTHERS—NO PICTURES AVAILABLE

E. T. McENERY, M. D.: Assistant clinical professor of pediatrics, Stritch School of Medicine, Loyola University, Chicago

SPRAGUE H. GARDINER, M. D.: Assistant professor of obstetrics and gynecology, Indiana University School of Medicine, Indianapolis

CANNON

2:00 p. m.: PROTEIN NEEDS IN CHILDREN (Newborn and the Pre-School Group): E. T. McEnery, M. D., assistant clinical professor of pediatrics, Stritch School of Medicine, Loyola University, Chicago

2:30 p. m.: THE DIETARY MANAGEMENT OF THE PREGNANT PATIENT: Allan C. Barnes, M. D., professor of obstetrics and gynecology, Ohio State University College of Medicine, Columbus

3:00 p. m.: RECESS TO VIEW EXHIBITS
Demonstration on "Manual Artificial Respiration" to be repeated.

3:45 p. m.: CAUSES AND TREATMENT OF THE CLINICALLY SIGNIFICANT HYPOGLYCEMIAS: W. W. Engstrom, M. D., assistant professor of medicine, Marquette University School of Medicine

4:05 p. m.: SOME PROBLEMS OF PARENTERAL ALIMENTATION: Paul R. Cannon, M. D., professor and chairman of the department of pathology, University of Chicago

4:35 p. m.: PSYCHOSOMATIC GYNECOLOGY: Sprague H. Gardiner, M. D., assistant professor of obstetrics and gynecology, Indiana University School of Medicine, Indianapolis

Dinner Speaker

C. WALTER McCARTY, Editor, Indianapolis News. Mr. McCarty is one of the most brilliant speakers of the "Fourth Estate" in the midwest, and we look forward to his address on "JOURNALISTIC OBSTETRICS."
Limited attendance, so make your reservations immediately. Use blank on page 805.

■ J. W. GALE, M. D.
Moderator, General Session

Scientific Programs for WEDNESDAY, OCT. 8

9:00–10:00 A. M.: Small Group Teaching Programs

OBSTETRICS AND GYNECOLOGY — Stage of Exhibit Hall

ANESTHESIA AND OBSTETRICS: Showing of appropriate film and discussion led by O. Sidney Orth, M. D., professor of anesthesiology, University of Wisconsin, and William V. Luetke, M. D., Madison

FRACTURE DEMONSTRATION—Stage of Exhibit Hall

Same demonstration as on Monday and Tuesday (see Monday program for description).

X-RAY INTERPRETATIONS—Dressing Room East of Stage

COMMON LESIONS OF THE SKULL AS REVEALED BY X-RAY: Lester W. Paul, M. D., Madison

(Those attending are invited to bring with them interesting and significant x-rays for discussion.)

MANUAL ARTIFICIAL RESPIRATION — Foot of Stage

Same demonstrations as on Monday and Tuesday (see Monday program for description). Demonstration will be on morning of Oct. 8 only.

Related Teaching Exhibits

ANATOMY: Dissections and discussion on "The Anatomy of the Abdominal Cavity:" U. of W. Anatomy Dept. Doctors O. V. Hibma and Otto Mortensen as demonstrators, at foot of stage.

GROSS TISSUE: The Wisconsin Society of Pathologists will again present interesting displays and discussions on pathologic material of special significance. Located near foot of stage.

EXHIBIT DEMONSTRATIONS: Several scientific and technical exhibits will have special demonstrations of a scientific character. See official program for details.

Wednesday, Oct. 8

10:15–11:30 A.M.: Special Symposia — SURGERY—PEDIATRICS RADIOLOGY

"DEVELOPMENTAL REQUIREMENTS IN CHILDHOOD"

JUNEAU HALL MILWAUKEE AUDITORIUM

F. J. MELLENCAMP, M. D., Milwaukee, Moderator

NUTRITIONAL ASPECTS OF CHILD GROWTH: John A. Anderson, M. D., professor and head of the department of pediatrics, Stanford University School of Medicine, San Francisco

SIGNIFICANT ENDOCRINE PROBLEMS IN CHILD GROWTH: Edgar S. Gordon, M. D., associate professor of medicine, University of Wisconsin Medical School

EMOTIONAL PROBLEMS OF GROWING CHILDREN: Reynold A. Jensen, M. D., associate professor of pediatrics, University of Minnesota Medical School, Minneapolis

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"SIGNIFICANT SURGICAL PROBLEMS"

SOUTH KILBOURN HALL MILWAUKEE AUDITORIUM

MAURICE RICE, M. D., Stevens Point, Moderator

CANCER OF THE HEAD AND NECK: Hayes Martin, M. D., assistant professor of clinical surgery, Cornell University Medical College, New York City

(By action of the Council on Scientific Work this presentation will be 1 hour in length, from 10:15–11:15 a.m.)

THE CLINICAL IMPORTANCE OF PANCREATIC FUNCTION TESTS: Robert Elman, M. D., professor of clinical surgery, Washington University School of Medicine, St. Louis, Mo.

SPECIAL PROGRAM ON RADIOLOGY

WALKER HALL MILWAUKEE AUDITORIUM

RUSSELL WILSON, M. D., Beloit, Moderator

MYELOGRAPHY: DIAGNOSTIC ASPECTS RELATED TO THE SUBJECT: Harold O. Peterson, M. D., clinical associate professor of radiology, University of Minnesota Medical School, Minneapolis

SIGNIFICANT CASE STUDIES (10 Minutes Each)

Irradiation Studies with the Archer Lead Glass Fiber Protective Apron: T. L. Pfeffer, M. D., assistant clinical professor of radiology, Marquette University School of Medicine

The Lung in Uremia: W. L. Waskow, M. D., Madison

Evaluation of Routine Roentgen Pelvimetry: Abraham Marck, M. D., Milwaukee

A Pediatric Case Report: H. W. Hefke, M. D., associate clinical professor of radiology, Marquette University School of Medicine

ROUND TABLE LUNCHEONS—WEDNESDAY, OCT. 8

All Luncheons at Hotel Schroeder

FOURTH FLOOR LOCATIONS:

1. Parlor A: **The Choice of Medical vs. Surgical Therapy in Massive Upper Gastrointestinal Hemorrhage:** Robert Elman, M. D., St. Louis, Missouri (Joseph Gale, M. D., Madison, Chairman)
2. Parlor B: **Cancer of the Head and Neck:** Hayes Martin, M. D., New York (E. R. Schmidt, M. D., Madison, Chairman)
3. Parlor C: **Treatment of Vaginal Discharge:** Benjamin E. Urdan, M. D., Milwaukee
4. Parlor D: **Nephrosis in Children:** John Anderson, M. D., San Francisco (John Gonce, M. D., Madison, Chairman)
5. Parlor E: **Newer Drugs and Their Uses:** O. O. Meyer, M. D., Madison
6. Parlor G: **Recent Advances in Hormonal Therapy in Cancer:** A. R. Curreri, M. D., Madison
7. Parlor F: **Metabolic Problems in General Practice:** E. S. Gordon, M. D., Madison
8. Parlor H: **Indications and Limitations of ACTH, Cortisone, and the Antihistamine Drugs in Dermatologic Treatment:** Harry Foerster, M. D., Milwaukee
9. Parlor I: **The Treatment of Head Injuries:** David Cleveland, M. D., Milwaukee

FIFTH FLOOR LOCATIONS:

10. Room 507: **"Anxieties" as Seen in the Practice of Medicine:** Elwood Mason, M. D., Milwaukee
11. Room 508: **The Child Who Fails in School:** Reynold A. Jensen, M. D., Minneapolis (H. Kent Tenney, M. D., Madison, Chairman)
12. Committee Room: **Problems of Hypertension:** Charles Crumpton, M. D., Madison
13. Pine Room: **The Treatment of Bronchial Asthma:** Howard Lee, M. D., Milwaukee
14. Pere Marquette: **Roentgen Diagnosis of Benign Gastric Ulcers:** Harold Peterson, M. D., Minneapolis (S. A. Morton, M. D., Milwaukee, Chairman)

SPECIAL LUNCHEON AND SECTION MEETING

15. East Room (Fifth Floor, Hotel Schroeder): LUNCHEON FOR SECTION ON OPHTHALMOLOGY AND OTOLARYNGOLOGY:

[SEE NEXT PAGE FOR SECTION PROGRAM]

NOTE: LUNCHEONS FILLED AT TIME OF PUBLICATION: 1

2:00 P. M.: *Closing General Session* — CRYSTAL BALLROOM HOTEL SCHROEDER

ELMAN

J. W. GALE, M. D., Madison, Moderator

2:00 p. m.: DEGENERATIVE DISEASES OF THE HIP: Charles Ihle, M.D., Eau Claire

2:20 p. m.: ELECTROLYTE AND NUTRITIONAL BALANCE: Robert Elman, M. D., professor of clinical surgery, Washington University School of Medicine, St. Louis, Mo.

2:50 p. m.: THE PATHOGENESIS OF RHEUMATIC FEVER: John A. Anderson, M. D., professor and head of the department of pediatrics, Stanford University School of Medicine, San Francisco

(Entire program will be concluded at 3:20 p. m.)

HAAS

Section on

OPHTHALMOLOGY

and

OTOLARYNGOLOGY

HILDING

EAST ROOM—HOTEL SCHROEDER—FOLLOWING LUNCHEON

GEORGE NADEAU, M. D., Green Bay, Acting Chairman

1:00 p. m.: Business Meeting and Election of Delegate for 1953 House of Delegates

1:30 p. m.: SOME NEW POINTS IN COCHLEAR ANATOMY AND PHYSIOLOGIC IMPLICATIONS: Anderson C. Hilding, M. D., clinical professor of ophthalmology and otorhinology, University of Minnesota Medical School, Minneapolis

2:00 p. m.: THE PRESENT STATUS OF ORTHOPTICS IN OPHTHALMOLOGY: John Hitz, M. D., associate clinical professor of ophthalmology, Marquette University School of Medicine

2:20 p. m.: NEWER METHODS OF DETECTING HEARING LOSS: Charles R. Taborsky, M. D., assistant clinical professor of otolaryngology, University of Wisconsin Medical School

2:40 p. m.: TREATMENT OF SHALLOW ANGLE GLAUCOMA: Joseph S. Haas, M. D., assistant professor of ophthalmology, University of Illinois Medical School, Chicago

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OTHER WEDNESDAY OUT-OF-STATE SPEAKERS

ANDERSON

PETERSON

MARTIN

■ P. A. MIDELFART, M. D.

The Scientific Exhibits

Your attention is directed to the various scientific exhibits described on the following pages. These teaching exhibits have been arranged for the Council on Scientific Work by P. A. Midelfart, M. D. Each day there will be time in the morning and afternoon to study the exhibits presented.

S-8 EXAMINING THE SCHOOL CHILD

State Board of Health and Bureau of Handicapped Children, State Department of Public Instruction

Using an exhibit prepared by the American Medical Association on "The Examination of the School Child" certain modifications will be made to illustrate what is being done in this field in many Wisconsin schools. A second portion of the exhibit will illustrate the development of the hearing program conducted by the Bureau of Handicapped Children as an illustration of what can be done through cooperative efforts of lay and professional groups, with a state agency serving to coordinate the work and assisting with necessary follow up.

S-9 ETIOLOGY OF PEPTIC ULCERS AND RELATIONSHIP TO THERAPY

M. C. F. Lindert, M. D., J. J. Levin, M. D., and R. J. Mayer, M. D., Veterans Administration Center, Wood, and Marquette University School of Medicine

The etiology of peptic ulcers is unknown. The various factors involved in the etiology of peptic ulcers will be discussed. Some of the numerous and varied drugs used in the treatment of peptic ulcer will be discussed, and an attempt will be made to show the site or sites of action of the various drugs used.

S-10 DIABETES

Bruno J. Peters, M. D., Veterans Administration Center, Wood, and Marquette University School of Medicine

The exhibit deals with the problem of the placement of diabetics in industry. Precautions necessary to protect diabetics from injury are listed and discussed. Jobs contraindicated are listed together with possible complications that may arise because of the presence of diabetes; and medical department responsibilities are listed and discussed.

S-11 CARDIAC CATHETERIZATION IN CONGENITAL
S-12 AND ACQUIRED HEART DISEASE

Marquette University School of Medicine and the Variety Club Heart Center

The exhibit will feature illustrations of various catheter positions and also charts illustrating impressive data obtained in various types of congenital malformations of the heart. The type of graphic recordings that are obtained in various conditions in which cardiac catheterization is important for diagnosis will also be on display.

S-13 EXPERIMENTAL STUDY OF ETIOLOGY OF ATHEROSCLEROSIS

Silas M. Evans, M. D., and Wisconsin Heart Association

It has been observed that blood from certain patients, when pulsated under physiologic conditions against a fresh human aorta obtained at autopsy, produces a change in the aortic wall similar to that seen in atherosclerosis. This phenomena will be demonstrated, together with statistical evaluation of the correlation between the clinical sources of blood and the above described experimental results, if any, to the general physician public.

S-24 RHEUMATIC DISEASE OF HANDS: DIFFERENTIAL DIAGNOSIS

M. W. Garry, M. D., Wisconsin Rheumatism Association, Marquette University School of Medicine and Veterans Medical Center, Wood

Signs of rheumatologic involvement of the hands and fingers are common and important in practice. The differential diagnosis is occasionaly difficult, since a number of disorders may present their initial manifestation in these areas. An exhibition of the commoner rheumatic affections of the hands and fingers will be presented along with some of the diagnostic problems most frequently encountered. The display will be in the form of color transparencies with appropriate legends.

S-25 INFECTIOUS DISEASE CONTROL IN A GENERAL HOSPITAL

B. A. Waisbren, M. D., Marquette University School of Medicine and Milwaukee County Hospital

The theme of the exhibit is that service, research, and teaching are necessary for effective control of infections in a general hospital. The way to set up the tube dilution method of determining bacterial sensitivity to antibiotics will be shown. The comparative sensitivity to antibiotics of a large group of organisms isolated from patients will be demonstrated. Some research

projects of the Infectious Disease Control Unit of the Milwaukee County General Hospital will also be on display.

S-26a INTRACRANIAL ANEURYSMS AND VASCULAR S-31a ANOMALIES

H. M. Suckle, M. D., Madison

The exhibit is designed to demonstrate the general statistics, the occurrence of intracranial aneurysms and vascular anomalies, and the prognosis with treatment. The important diagnostic signs are pictured. The diagnostic method of arteriography is fully illustrated and the methods of treatment, not only with carotid ligation but also the intracranial approach, is illustrated.

S-26 ATTRITION OF THE SHOULDER

F. J. Krueger, M. D., Milwaukee

A demonstration of etiology, pathomechanics, anatomical considerations, and treatment of attritional changes in the shoulder, with particular emphasis on posture as it relates to rotator cuff and scapulocostal syndromes, will be presented.

S-27 SURGERY OF THE MANDIBLE

R. P. Gingrass, M. D., Milwaukee

This exhibit will consist of kodachrome slides and x-rays of congenital and acquired malformations and diseases of the mandible. Prognathism, ankylosis, dislocations, microgenia, pathologic fractures, cysts and tumors, etc. will be illustrated with before and after photographs and x-rays.

S-28 PLASTIC SURGERY

S-29

F. D. Bernard, M. D., University of Wisconsin Medical School

Pictoral representation of the surgical treatment of the following will be presented.

1. Congenital anomalies
2. Traumatic facial injuries
3. Burns, early and late treatment
4. Cosmetic surgery
5. Orthopedic coverage

S-14a GROSS TISSUE EXHIBIT

S-19a Wisconsin Society of Pathologists

The exhibit entails the showing of gross tissues and organs obtained at operation and autopsy, with demonstration of the features characteristic of the various lesions.

S-14 MILWAUKEE CANCER DIAGNOSTIC CLINIC, INC.

Operated by Marquette University School of Medicine in cooperation with the Milwaukee Division of the American Cancer Society and the Health Department of the City of Milwaukee

The exhibit is designed to show the principles of operation, which patients are eligible, the scope of the examination done, the number of patients examined since the Clinic opened on Nov. 15, 1950, and the number and types of cancers found. Various x-ray films of malignant lesions will be displayed.

S-15 TEAMWORK IN CANCER DIAGNOSIS

S-16 Wisconsin Division, American Cancer Society

The exhibit will emphasize the teamwork necessary in cancer diagnosis, the team composed of the patient, the family physician, the pathologist, the surgeon, and the radiologist. The importance of biopsy technique is stressed as well as the clinical signs of certain forms of cancer.

S-17 INFANT AND MATERNAL MORTALITY RATES

S-18 Wisconsin Academy of General Practice

The exhibit will deal with infant and maternal mortality rates during the past 20 years. These years have seen hundreds, indeed thousands, of mothers saved with the advent of antibiotics, blood banks, and careful prenatal care. Inasmuch as general practitioners deliver approximately 85 per cent of all babies born in Wisconsin, this exhibit will be a tribute to them and to the obstetricians of our state, who lead the nation by having one of the lowest infant and maternal mortality rates.

S-19 EVALUATION OF EXPERIMENTAL DRUGS IN THE TREATMENT OF ESSENTIAL HYPERTENSION

H. H. Shapiro, M. D., and C. W. Crumpton, M. D., University of Wisconsin Medical School

S-20 ELECTROENCEPHALOGRAPHY

F. J. Millen, M. D., and M. J. Primakow, M. D., Veterans Administration Center, Wood, and Marquette University School of Medicine

The exhibit will consist of cut outs of electroencephalograms with case histories attached as seen in various neurologic and psychiatric disorders; placards explaining various phases of electroencephalography; and an electroencephalograph machine to demonstrate technique.

S-21 SECTION ON RADIOLOGY

S-22

S-23

The exhibit as in previous years will be individual exhibits of pertinent and interesting aspects of radiologic diagnosis in disease conditions, with special attention on the radiologic aspects of these diseases. If specific types or new types of radiologic procedures are necessary, these will be described. The exhibit is to be a representative group of exhibits from radiologists throughout the State of Wisconsin. A purpose of the exhibit is to familiarize physicians outside of the field of radiology with procedures used by the radiologists and to describe new techniques and diagnosis.

S-30 MERTHIOLATE BONE BANK

P. L. Carnesale, M. D., P. J. Collopy, M. D., and J. O'D. McCabe, M. D., Veterans Administration Center, Wood, and Marquette University School of Medicine

The exhibit will consist of a series of serial translights including preoperative and follow-up studies illustrating the roentgenologic findings following the use of homogenous bone grafts preserved in merthiolate solution. The cases include defects of long bone, non-unions, spinal fusions, and arthrodeses of joints.

(Continued on page 805)

Scientific Programs of Special Groups

WISCONSIN CHAPTER American College of Chest Physicians

HOTEL SCHROEDER — SUNDAY, OCT. 5

1:00 p. m.: REGISTRATION AND VIEWING OF EXHIBITS: 5th Floor

2:00 p. m.: SCIENTIFIC PROGRAM: Crystal Ballroom: 5th Floor

PROBLEMS IN THE DIAGNOSIS OF CHEST DISEASE: Herbert W. Schmidt, M. D., Rochester, Minnesota

CLINICAL DIAGNOSIS AND TREATMENT OF EMPHYSEMA IN THE PATIENT PAST FORTY: Edwin R. Levine, M. D., Chicago

TUMORS OF THE CHEST IN CHILDREN: Gorton Ritchie, M. D., Milwaukee

TREATMENT OF INOPERABLE CANCER OF THE LUNG: Edgar Mayer, M. D., New York City

PRECORDIAL MIGRAINE: John F. Briggs, M. D., St. Paul, Minnesota

6:00 p. m.: DINNER: Club Rooms, 3rd Floor

Address: CLINICAL APPLICATION OF RECENT ADVANCES IN CARDIOPULMONARY PHYSIOLOGY: Aldo A. Luisado, M. D., Chicago

Wisconsin Society of Anesthesiologists

HOTEL SCHROEDER — SUNDAY, OCT. 5

2:00 p. m.: BUSINESS MEETING

3:30 p. m.: RESUSCITATION IN THE OPERATING ROOM: Claude Beck, M. D., professor of cardiovascular surgery, Western Reserve University School of Medicine, Cleveland

(This will be essentially the same lecture as Doctor Beck will present at the General Scientific Session on Monday afternoon at 2:00 p.m. It will include the showing of a film on the subject, and supplementary remarks by Doctor Beck.)

5:30 p. m.: SOCIAL HOUR

6:30 p. m.: DINNER

THE MEDICAL FORUM

SELECTIVE SERVICE CLASSIFYING PRIORITY III M.D.'s

SOCIETY SPONSORS CONFERENCE ON PHYSICIANS AND SCHOOLS, OCT. 17–18

Madison, Aug. 6.—The State Medical Society will sponsor the first Wisconsin Conference on Physicians and Schools to be held at the Memorial Union Building, Madison, October 17–18.

Dr. F. J. Mellencamp, Milwaukee, chairman of the Committee on School Health, said the conference will outline the responsibilities of physicians, parents, teachers and school administrators "in adjusting school programs to meet the individual needs of children."

The conference was promoted by Dr. A. H. Heidner, West Bend, State Medical Society president, as part of his program of bringing the medical profession into closer contact with the "interest groups which govern our society today."

Co-sponsors of the meeting with the State Medical Society are the Wisconsin State School Health Council, State Board of Health, State Department of Public Instruction, Wisconsin Congress of Parents and Teachers, and the University of Wisconsin School of Education.

"Unparalleled Opportunity"

Keynote speakers for the conference include Dr. W. W. Bauer, director of health education of the American Medical Association; Dr. George M. Wheatley, of Metropolitan Life Insurance Company, New York; Clyde Parker, superintendent of schools at Cedar Rapids, Ia., and Fred V. Hein, Ph.D., consultant with the bureau of health education of the AMA.

"Physicians and teachers have an unparalleled opportunity and responsibility to educate our youth for health," Dr. Heidner declared. "The medical profession in Wisconsin welcomes this opportunity to explain to our teachers the value of high quality medical care and how to make wise use of professional health services."

(Continued on page 798)

DR. F. J. MELLENCAMP

Important Notice to Recent Graduates in Medicine

Madison, Aug. 1.—State Selective Service reports evidence that a number of recently graduated physicians have failed to register with Selective Service within 5 days after graduation as required by law.

Milwaukee local boards particularly believe that the number of physicians who presented themselves for registration was disproportionate to the number graduated.

Some graduates may have failed to register in the belief that a questionnaire circulated among them prior to graduation by the Wisconsin Advisory Committee to Selective Service was sufficient to constitute registration. This is not the case.

Any recently graduated physician who has not registered with his local board since graduation should do so at once.

Penalties of $10,000 and/or five years imprisonment are provided for failure to register.

Madison, Aug. 1.—Wisconsin Selective Service local boards have received instructions from national headquarters to start the classification of all Priority III physicians and dentists, the State Medical Society has been advised.

This means that nearly 635 physicians and over 400 dentists will soon receive "I–A" notices from their local boards, if they have not already been so notified. This notice is preceded by a request to fill out a Classification Questionnaire (SSS Form No. 100) and three copies of Initial Data for Classification and Commissioning in Medical, Dental and Veterinary Corps (DD Form No. 390.)

When these forms are returned the local board is instructed to proceed with classification and physical examination of each registrant.

To order the physician for physical examination the local board is required to place him in a I–A classification. Consequently, it can be assumed that most if not all Priority III physicians will receive this notice during August or September.

At the same time that the physical examinations are being com-

(Continued on page 798)

THIS IS A PRIORITY III REGISTRANT

A special registrant who did not participate as a student in the Army specialized training program or any similar program administered by the Navy, and was not deferred from service during World War II for the purpose of pursuing a course of instruction leading to education in a medical, dental or allied specialist category is in the third order of priority IF HE HAS HAD NO ACTIVE SERVICE IN THE ARMY, AIR FORCE, NAVY, MARINE CORPS, COAST GUARD, OR PUBLIC HEALTH SERVICE SUBSEQUENT TO SEPTEMBER 16, 1940.

SELECTIVE SERVICE . . .

(Continued from page 797)

pleted, the Wisconsin Advisory Committee to Selective Service will be investigating the essentiality of each registrant to make a recommendation of "available for service" or "essential" for the local board.

All appeal rights for Priority III physicians are extended and preserved until after the Advisory Committee's recommendation has been received and evaluated by the local board.

Each Priority III physician will receive a copy of the Advisory Committee's recommendation at the time it is sent to the local board.

The State Medical Society, in reviewing the current situation, points out that a I–A classification of a Priority III physician at this time **does not mean that the physician will be drafted.**

The physical examination and determination of essentiality are being made now as a part of advance planning in the event that the call-up of Priority III physicians becomes necessary. Unofficially, it is estimated that it may be six to 12 months before such a situation materializes.

Physicians are urged to complete all processing requested by Selective Service local boards at this time, including physical examinations. Appeal from the I–A classification, if the physician desires to pursue it, is not necessary prior to local board consideration of the Advisory Committee recommendation.

Physicians in Priority III may submit any information bearing on their essentiality to the Wisconsin Advisory Committee to Selective Service at the office of the State Medical Society.

Call 355 M.D.s to Service in September

Washington, D. C., July 30.—The Department of Defense has requested the Selective Service system to deliver to armed forces induction stations 355 physicians during the month of September.

The Armed Forces will assign 180 physicians to the Army and 175 to the Air Force.

The September call for physicians brings to a total of 1,522, the number of physicians requested since July, 1951.

GP's Annual Meeting in Madison, Nov. 10–12

Madison, Aug. 1.—The fourth annual meeting of the Wisconsin Academy of General Practice will be held in Madison, November 10, 11 and 12, at the Loraine Hotel.

General Program Chairman Dr. S. S. Sorkin, Evansville, states that the House of Delegates of the Academy will meet on November 10. Scientific sessions will be held November 11 and 12.

Dr. Sorkin emphasized the necessity of making early reservations for hotel or motel accomodations. Any physicians having difficulty finding accomodations are urged to contact Dr. Theodore Nereim, 110 E. Main St., Madison, housing chairman of the annual session.

Full details of the session will be published in the September and October Wisconsin Medical Journal.

Vets Can Fill Prescriptions Locally

Madison, Aug. 1.—When drugs are needed immediately by a veteran who is authorized outpatient medical treatment, the physician is permitted to authorize the immediate filling of a prescription at the local pharmacy.

T. J. Doran, director of the Veterans Medical Service Agency of the State Medical Society, calls attention to this procedure as a means of eliminating any misunderstanding among physicians on this point.

Two methods of filling prescriptions for veterans are authorized:

1. **When the medicine is immediately needed, the physician should make a statement on the prescription to the effect that he is authorized to treat and prescribe for the particular veteran. The veteran then takes the prescription to the local druggist who may fill it immediately.**
2. **Prescriptions may also be filled in the Regional Office of the VA in Milwaukee. This method is not advisable when the drug is needed at once.**

Physicians are urged to follow the first method whenever the need for drugs is immediate and the physician has authorization to treat the veteran.

SCHOOL HEALTH . . .

(Continued from page 797)

Dr. Mellencamp urged every Wisconsin physician with an interest in school health to attend the first conference and participate in its sessions.

"As parents, school board members, school physicians and medical advisors to Wisconsin schools, all medical society members can appreciate the importance of this conference in determining the guiding principles of good school health practices," he said.

Dr. Heidner and President E. B. Fred of the University of Wisconsin will welcome guests to the conference. Drs. C. N. Neupert, state health officer, and W. D. Stovall, director of the state laboratory of hygiene, are scheduled to speak.

Five workshop sessions on major health education topics have been scheduled for the two days: Discussion will center on health examinations, control of disease, emergency medical care in schools, physical education, and emotional problems of the growing child.

Chairmen for these sessions include Dr. E. H. Pawsat, Fond du Lac, health chairman of the Wisconsin Congress of Parents and Teachers; Dr. George Shinners, district health officer at Green Bay; Leslie Johnson, superintendent of schools at Superior and president of the Wisconsin Education Association; Homer de Long, superintendent of schools at Eau Claire, and Dr. H. K. Tenney, Madison.

FSA Calls Conference on Problems of Aging

Wisconsin Invited to Send Representatives

Washington, D. C., July 23.—The Federal Security Agency has called a conference of State Commissions on Aging to be held in Washington September 8–10.

The delegates will center their attention on the work of state groups dealing with problems of the aged, including health maintenance, medical care and rehabilitation. Wisconsin is one of the fifteen states with commissions dealing with problems of the aged. Mr. T. J. Doran, director of the Wisconsin Veterans Medical Service Agency of the State Medical Society, is a member of the Wisconsin commission.

M.D.'s HAVE ROLE IN NURSING HOME STANDARDS

Requirements on Medications, Nursing and Physical Examinations Affect Doctor

Madison, Aug. 1.—Physicians have a definite responsibility in helping nursing homes maintain proper medical standards required to qualify them for full license, reports the State Board of Health.

Starting July 1 of this year all nursing homes in Wisconsin were given provisional or full licenses upon compliance with the "Standards for the Maintenance and Operation of Nursing Homes" set by the State Board of Health.

Aged persons living in nursing homes are not eligible to receive federal old age assistance funds unless the home meets these standards.

The standards were compiled by a special Advisory Committee on Nursing Homes on which Dr. Raymond S. Hirsch, Viroqua, represented the State Medical Society.

Dr. Hirsch said that the standards cover all phases of nursing home maintenance, operation, construction and enforcement.

List Standards

He pointed out that physicians will be particularly interested in the standards requiring physical examinations of nursing home personnel and patients. They provide that:

1. **All nursing home personnel, including the person in charge, and all patients who have not had a complete physical examination, including an x-ray of the chest, within a 30-day period prior to being admitted to the nursing home, or beginning work in the nursing home, shall have a physical examination within one week thereafter. The physical examination shall be made by a physician licensed in Wisconsin and selected by the person examined or his agent. The physician shall certify in writing to the licensed operator of the nursing home that the person examined has had a physical examination, including an x-ray of the chest, and is free of any communicable disease.**

DR. E. H. JORRIS

2. **A patient transferred from a hospital can be admitted to the nursing home upon certification in writing by a physician that the patient has had a physical examination, including an x-ray of the chest, at the hospital and is free of any communicable disease.**
3. **Any employee shall be excluded from work who is suspected of having a communicable disease or who has been diagnosed by a physician as having a communicable disease.**
4. **It is recommended that both nursing home personnel and patients have annual physical examinations.**

Other standards relate to nursing care and the medications. "These have special concern to physicians," Dr. Hirsch points out, "and should be known to all those who are in any way concerned with the local supervision of nursing homes."

Commenting on the need for local support of the program, Dr. E. H. Jorris, assistant State health officer and secretary of the advisory committee, said, "Nursing homes, unlike general hospitals, do not have an organized medical staff; therefore, it is believed that there should be one physician designated who would encourage the operator of the home to maintain the minimum standards established and to assure adequate medical supervision of the patients."

"Very often the operator of the nursing home is neither a registered nurse nor a licensed trained practical nurse," Dr. Jorris pointed out. "For persons with limited experience in the care of the sick, the need for written orders spelled out in terms readily understandable becomes increasingly important."

"If physicians have any suggestions for the improvement of these standards from the viewpoint of supervision of medical care, they will be most welcome and will be given serious consideration at the time of the annual revision," Dr. Jorris explained.

CLAIM BLANKS

A Wisconsin doctor is likely to handle more TIME claim blanks than any other company's. TIME, a leader in the accident and health insurance field, insures a large portion of the total number of persons carrying such insurance in Wisconsin.

Few doctors appreciate the great service given to their patients when these claim forms are handled promptly.

Any suggestions from you as to how our claim forms may be improved will certainly be appreciated.

• • •

The Time Insurance Company

213 WEST WISCONSIN AVENUE

Milwaukee 3, Wis.

THE CANDIDATES SPEAK ON HEALTH INSURANCE

The following statements have been reproduced from a bulletin issued by the American Medical Association National Education Campaign, Dr. Elmer L. Henderson, chairman.

DWIGHT D. EISENHOWER

Republican Nominee for President

At his press conference in Abilene, Kansas, on June 5, 1952, Eisenhower was asked the question: "Are you for Compulsory Health Insurance?"

Here is Mr. Eisenhower's reply:

"I am not going to answer too specifically, because what could be in a bill labeled compulsory health insurance? I am not so certain. But I can tell you this: I am quite certain over the years that I was at Columbia, no one spoke out more than I did against the centralization of power in Washington, against bureaucratic government and submitting our lives toward a control that would lead inevitably to socialism . . . I do believe that every American has a right to decent medical care."

In discussing Federal aid to medical education, Mr. Eisenhower said that in private universities we must "support medical education by private means, because if we didn't it would be the first step toward the socialization of medicine, and I am against socialization."

RICHARD M. NIXON

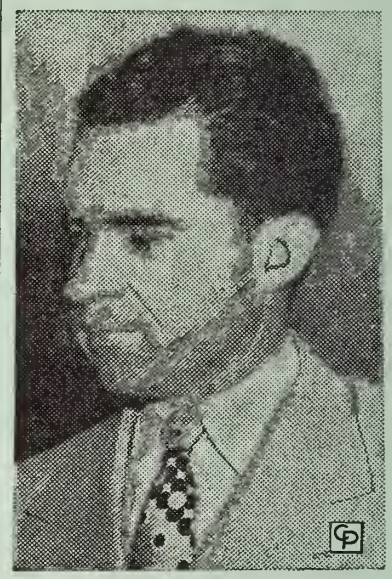
Republican Nominee for Vice President

(Excerpts from address delivered before the seventh annual meeting, Conference of Presidents and Other Officers of State Medical Associations, Atlantic City, June 10, 1951.)

"I would like . . . . to express my congratulations to the members of this group, and to the medical profession generally, for the very splendid political action the medical profession took in the last campaign leading up to the November election, and in other previous campaigns. As a result of that action, I think we can safely say that . . . there is no chance whatever at this time for any type of compulsory health insurance program to be enacted . . . . On the other hand, I think you must recognize, and that all of us who are interested in this fight must recognize, that those who favor such legislation will continue to work fanatically for their cause, in the hope that somehow, sometime in the future, they will be able to accomplish their purpose."

"I think . . . . that a great number of people, probably a majority of the people in the country, are convinced that the compulsory health insurance programs which sound so good in theory have not worked out in action in those nations which have tried them."

"I am convinced that the medical profession has taken a very long step in the right direction with its recently announced program of subsidizing medical schools on a voluntary rather than on a government basis. I would suggest also that additional voluntary action is needed (in dealing with) the problem of encouraging wherever possible voluntary health insurance programs. It seems to me that the objective toward which we should work in the United States is a system where eventually anybody who wants health insurance can get it—where those who should have health insurance are encouraged to get it—but where no one in the United States is compelled to take out such insurance against his will. If the profession adopts that objective we will remove by voluntary action the strongest arguments that the proponents of government control



of the medical profession have at the present time."

"I believe it is essential that all members of the medical profession recognize that an attempt to socialize any American profession —any American institution—constitutes a threat to all."

"Traditionally, the great accomplishments in this country have not been through government action, but through individual and cooperative action . . . . (Our task) is by precept and by example, to prove to the people of the world that a free people, working as individuals, working cooperatively, can solve the problems of our society and can solve them more effectively than can a government."

Hoover Sees Spooks in Give-Away Programs

Chicago, July 14.—Herbert Hoover was given a big hand when he mentioned socialized medicine in connection with the government's give–away program before the Republican National Convention in Chicago.

"If you want to see pure fascism mixed with give–away programs, take a look into the Brannan plan.

"If you want to see pure socialism mixed with give–away programs, take a look at socialized medicine and socialized electrical power."

ADLAI STEVENSON

Democratic Nominee for President

"I am against the socialization of the practice of medicine as much as I would be against the socialization of my own profession, the law . . . . If the insurance principle could be brought to bear on these catastrophic illnesses, it would largely eliminate the specter of terror from the average home . . . . I am sure that . . . . the common objective can be largely realized without the destruction of professional independence.

"Basically, the problem is how to lift people over the costs of major illness. I don't know whether voluntary plans can do the job. I think the new commission on medical needs may well add some light and remove some heat, enabling us to find a satisfactory solution to this perplexing problem."

On President's Commission

In a press conference on July 30, 1952, Mr. Stevenson was asked "whether he saw eye to eye with Federal Security Administrator Oscar Ewing" on the issue of Compulsory Health Insurance.

Mr. Stevenson's reply to this question was as follows:

"No, on a number of occasions in the past I have indicated that I thought a new approach was necessary. I emphatically believe that we must find some solution to the problem of catastrophic illness and its devastating expense.

"The President's Commission, of which my friend, Dr. Paul V. Magnuson is Chairman, might well come up with some recommendations and suggestions which would be more palatable, and I am hopefully awaiting the result of the deliberations."

DEMOCRATIC PARTY HEALTH PLANK

The following is the "health plank" of the Democratic Party Platform for 1952 as adopted in Chicago, July 23:

"We will continue to work for better health for every American, especially our children. We pledge continued and wholehearted support for the campaign that modern medicine is waging against mental illness, cancer, heart disease and other diseases.

"*Research:* We favor continued and vigorous support, from private and public sources, of research into the causes, prevention and cure of disease.

"Medical Education: We advocate federal aid for medical education to help overcome the growing shortages of doctors, nurses, and other trained health personnel.

"*Hospitals and Health Centers:* We pledge continued support for federal aid to hospital construction. We pledge increased federal aid to promote public health thru preventive programs and health services, especially in rural areas.

"Cost of Medical Care: We also advocate a resolute attack on the heavy financial hazard of serious illness. We recognize that the costs of modern medical care have grown to be prohibitive for many millions of people. We commend President Truman for establishing the non-partisan commission on the health needs of the nation to seek an acceptable solution of this urgent problem."

JOHN J. SPARKMAN

Democratic Nominee for Vice President

"I am in favor of adequate medical attention for the people of this country. However, I have not favored what is generally known as Socialized Medicine.

"I would be opposed to any plan which I thought would, in effect, socialize medicine, and to any medical program which would destroy the relationship of doctor and patient."

The foregoing statement was made by Mr. Sparkman in an interview with Mr. Al Goldsmith, editor of *Washington Insurance Newsletter*, on July 31, 1952.

In 1949, when the roll was called in the U.S. Senate on President Truman's Reorganization Plan No. 1, which would have created a Department of Welfare, Mr. Sparkman stood with medicine in opposition to this scheme to give Federal Security Administrator Oscar Ewing cabinet status.

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A FORUM FEATURE

THE MEDICAL STUDENT "VOICE"

STUDENT AMA HAS TWO CHAPTERS IN WISCONSIN

By ROY ZIMMER
President, University of Wisconsin Chapter Student American Medical Association

Eighteen months ago, the nation's medical students formed the Student American Medical Association. Today, it is ready to assume a contributory role of leadership and inspiration to medical and allied organizations.

The growth of SAMA has been consistent—not rapid. Last December, the SAMA held its first annual convention. More than 100 delegates from 41 medical schools were present. It currently has 43 chapters and nearly 10,000 members. Its goal, of course, is 100% participation by all medical schools. When this is accomplished, the SAMA can truly voice the opinions of the medical student body of America.

Marquette Admitted

One of the first actions of the first annual convention was the admission of three new school chapters to the organization. Among these three was Marquette Medical School of Milwaukee, thus giving Wisconsin's two medical schools representation in the historic first annual convention.

Reduce Journal Cost

Other major actions of the first SAMA convention were:

1. Local support to civil defense medical plans and operations.
2. Establishment of a committee on international relations to study the possibility of joining an international federation of medical student associations, to further the exchange of medical students, and the distribution of information of interest to medical students.
3. Seek to reduce the cost of state, county and specialty medical journals to SAMA members.
4. A study of Undergraduate Medical Curriculum by the SAMA's committee on education.
5. Support for the national blood procurement program and appreciation for the program of the American Medical Education Foundation.

OBJECTIVES OF STUDENT AMA

1. Creates common bond between students from different medical schools.
2. Publishes a Journal of high quality 9 months each year.
3. Provide films, speakers and package library service through the facilities of the AMA.
4. Make loans or grants, whenever possible, to students for continuing their medical education.
5. In cooperation with existing facilities, there will be a physicians' placement service for both interns and recent graduates.
6. Seek establishment of a nationwide hospital and surgical insurance plan which would cover medical students not only during the school year but during summer and other vacation periods.
7. Serve as a clearing house for summer jobs, and list available opportunities in allied professions.
8. Sponsor scholarships, summer seminars and advanced study for medical students.
9. Acquaint medical students with the socio-economic responsibilities and benefits of the medical profession.
10. Encourage membership of students on various committees of county, state and national medical societies, and their interest in active membership in medical societies when they enter practice.

One of the major undertakings by the association in its first year was the publication of a student scientific journal. With help of a generous loan of $30,000 from the American Medical Association to cover prepublication expenses, the 80 page Journal became a reality when the first issue was presented to the delegates at the convention. The Journal is to be published monthly and stands an excellent chance of showing considerable profit to the Association in the future.

For advertising purposes the Journal is being sent without charge to all medical students in the United States during this first year. Thereafter it will be sent to only those students who are members in their local societies and have their annual national dues of $1.00. The Journal is not devoted entirely to scientific material. The plan at present and for the future is to allocate 50% for strictly scientific material and 50% for articles of socio-economic and semi-scientific interest. The articles for the Journal are to be written by medical students, interns, residents, faculty members and graduate doctors. The student Journal stands out as one of the most important forward steps taken by the S.A.M.A. and one for which it can be justly proud.

Intern Placement Plan

Considerable discussion was held relative to the mechanical matching plan for placement of interns.

The present inflationary trend in internships is complicating more and more the problem of internship procurement for the students, as well as the problem of obtaining desirable interns by the hospitals. The hospitals today are finding it economically advantageous to have a resident and intern staff available and this is resulting in a great surplus of internships. Of the 10,000 internships offered this year, 3,500 will go unfilled. This surplus is deleterious to the students, and in view of this it was resolved that, following a statistical survey of internships, the S.A.M.A. initiate activity with the American Hospital Association and the A.M.A. in the attempt to improve and equalize the standards and compensation offered by the internships.

Try "Boston Plan"

As the result of several meetings, a matching plan incorporating features of the popular "Boston Pool Plan" is being tried this year on a voluntary basis. It is based on three rules:

1. A hospital lists its applicants in strict numerical order of its preference for candidates. This list is called the Hospital Preference List.
2. A man cannot be passed by a man below him on a Hospital Preference List. In other words, a candidate cannot advance on this Hospital Preference List until a man ahead of him is stricken from the list. A candidate is stricken from the hospital's list only when he has been accepted at another hospital which is higher on that candidate's own preference list.
3. A man always interns at the hospital highest on his choice list which offers him a position.

SAMA plans no competition with existing student societies. Instead, each chapter provides the mechanism for extending student service across school lines. Each chapter will grow according to the personality of its school. Benefits and objectives have been selected and it is believed that the Student American Medical Association is well on its way to acquiring a distinct and desirable personality of its own.

49 MILLION AMERICANS VOTED

But—

47 MILLION AMERICANS STAYED HOME!

*

That's What Happened in the Last Presidential Election

*

Speak Up!—Register!—Vote!

Medical Schools Receive Grants of $15,000 from Voluntary Fund

Madison, Aug. 1.—The University of Wisconsin Medical School and Marquette University School of Medicine each have received grants of $15,000 from the National Fund for Medical Education.

Each of the 79 medical schools in the nation received grants from this fund in July for unrestricted use in improving or maintaining training facilities.

More than $2,500,000 has been distributed to these schools during the past year by this fund, of which $1,417,752 came from the medical profession. The profession's contribution was made through the American Medical Education Foundation which conducts the drive among physicians. The National Fund for Medical Education collects funds from industry, labor, and allied health organizations. The two funds are pooled for distribution.

The doctors' campaign has set an annual goal of $2,000,000 and the other fund seeks $5,000,000 annually.

Commenting on the part played by physicians in the nationwide program to raise funds for "distressed" medical schools, the Journal of the American Medical Association has said editorially:

"It is thus clear that the medical profession is setting an example of self-help that should stimulate industry and other groups in American society to make their contributions in this important undertaking."

Hadacol to Start "Colorful" Campaign

New York, July 20.—A "major campaign in the true Hadacol manner: colorful and spectacular including spot radio and newspapers" is promised for September, according to *Editor and Publisher*.

The publishing magazine received its information from Harry Goldsmith, newly appointed president of the LeBlanc Corp. He was formerly president of Grove Laboratories and general sales manager for American Home Products.

Richland Society Uses Newspapers in PR

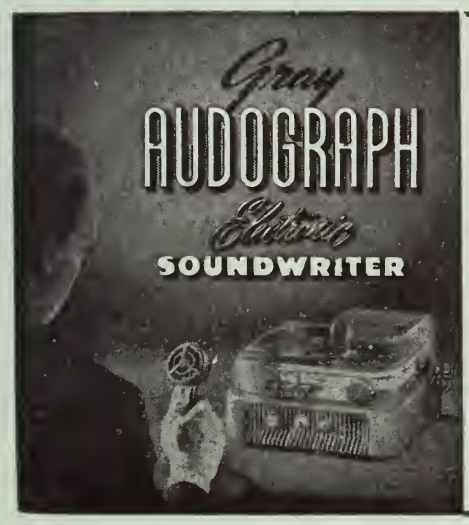
Richland Center, July 30.—A new step in the direction of better public relations is being utilized by the Richland County Medical Society.

Periodically, the Society issues a news release asking the public's cooperation on the handling of doctors' calls on the evenings that the Society holds its monthly scientific session.

A typical story from the local newspaper follows:

"The Richland County Medical Society meets on the second Tuesday of each month and since all physicians in this city wish to attend these meetings they have a policy of not being at their respective clinics after 5 p.m. on the meeting nights, but they may be reached at the Richland Hospital for urgent calls.

"They ask the public's kind cooperation."



A PROVEN AID FOR MDs

The GRAY AUDOGRAPH is not an experimental machine for doctors. Hundreds in and around Wisconsin are using it with complete satisfaction, as a means of speeding up their office work and increasing the efficiency of their secretarial help.

A Few Users in Madison . . .

STATE MEDICAL SOCIETY
DIV. MENTAL HYGIENE, DEPT. OF PUBLIC WELFARE
AMERICAN BOARD OF INTERNAL MEDICINE
WISCONSIN DIV., AMERICAN CANCER SOCIETY
JACKSON CLINIC VA HOSPITAL
ALBERT BONER, M.D. WILLIAM LEWIS, M.D.
STUART McCORMICK, M.D. RAY LUDDEN, M.D.

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THE COMING CLASS WAR— OLD VS. YOUNG*

(Reprinted from HARPER'S Magazine, July, 1952)

The enormous growth in the number of old people in America, and their increasing demands for pensions, may lead us to expect a new sort of class war—between our older and younger citizens. This will manifest itself in several ways.

First, there will be heavy pension taxes that may eventually absorb more than a quarter of the income of both workers and employers. This new class war may proceed so far that we will see workers and employers, despite their natural respect for age, standing shoulder to shoulder against the hard-driven politicians who promise our senior citizens impossible pensions. Point out the fallacies of the arguments for pensions all you like, but remember that the basic change in the population pattern is new and the resulting mass movement has not yet matured. Townsendism—which looked so foolish in the nineteen-thirties —may be as important in the next fifty years as were the doctrines of Karl Marx in earlier years. Since 1900 the percentage of eligible voters over 49 years of age has jumped from 24 to over 35.

Second, the common bond between employer and worker will grow stronger; as it does, the influence of the labor leader will diminish and the old class struggle will gradually subside.

Third, the pensionnaires, even retired union men, will tend to oppose higher wages because they cannot profit from them. If you doubt this, just sit on the green benches of St. Petersburg, Florida, and talk with pensioned union men. Citizens rctired from all walks of life will tend to be against any measure which tends to raise prices and reduce their buying power. They will strongly oppose inflation.

Our tremendously increased life expectancy at birth—from forty-seven years in 1900 to sixty-eight now—constitutes a major cultural and social revolution. I believe that this revolution is the basis for the "cradle-to-the-grave" movement, which would permit those close to the grave to fasten themselves on the backs of younger people, and ride piggy-back (or piggy-bank) to the grave.

***Frank G. Dickinson, economist and statistician of the American Medical Association, speaking (for himself and not necessarily for the AMA) before the Southern Conference on Gerontology. Condensed from Problems of America's Aging Population, University of Florida Press, 1951.**

DR. MacCORNACK REPRESENTS SOCIETY AT AREA BRUCELLOSIS CONFERENCE

Whitehall, Wis., Aug. 1.—Great improvement in the control of brucellosis in Wisconsin is already noticeable since the adoption of the state eradication law in 1951, according to Dr. R. L. MacCornack, Whitehall.

Dr. MacCornack represented the State Medical Society at the North Central States Conference on Brucellosis in Animals and Man, St. Paul, July 7–9. He is a member of the Council on Medical Service of the Society and chairman of the Annual Wisconsin Rural Health Conference.

Wisconsin has appropriated nearly $2,000,000 annually for eradication of diseases of domestic animals. The brucellosis control program involves milk ring testing of all herds twice each year, blood testing herds which react positively to ring test, and indemnity for elimination of reactors.

Dr. MacCornack reports that Minnesota has had over 3,000 cases of undulent fever from 1927 to 1947. At least 70 per cent of the cases were in men. The cases were divided as follows:

Farmers	1,147
Packing House Workers	533
Housewives	522

Dr. Wesley W. Spink, professor of medicinc at the University of Minnesota, told the conference that the disease is not transmissible from human to human. Although the disease may be contracted from raw milk and even farm dust, direct contact with infected tissue is the source of 75 per cent of the disease.

Dr. Spink does not believe there is such a thing as chronic brucellosis, and reported that the "usual treatment at this time is Aureomycin or Terramycin for two or three weeks combined with Dihydro–streptomycin."

To Require Physicals for Truck Drivers

Washington, D. C., May 19.—Starting on January 1, 1954, every truck, bus and taxi cab driver engaged in interstate commerce, must be physically re-examined at least once in three years.

The new requirements were announced by the Interstate Commerce Commission in a tightening up of a safety code. Both employer and the employee must have the physicians certificate available at all times on all drivers.

Visual acuity of not less than 20–40 in each eye (with glasses) will be required of new men, but drivers now on the job may qualify under the current standard until January 1, 1954. (current standard is 20–40 in one eye, 20–100 in the other)

VA Limits Use of TB Drug for Outpatients

Madison, July 30.—The VA has ordered that Isonicotinic Acid Hydrazide is *not* to be used or authorized in the treatment of outpatient tuberculous patients except where such treatment has been initiated in a VA hospital and its continuation on an outpatient basis is recommended by the hospital.

This instruction has been received by the Wisconsin Veterans Medical Service Agency from S. E. Sebastian, M.D., Chief Medical Officer of the VA Regional Office in Milwaukee.

The same restrictions apply to the use of streptomycin and PAS.

Dr. Sebastian reported that "this decision is based upon present lack of precise knowledge concerning optimal dosage, duration of therapy, chronic toxicity, and danger of emergence of hydrazide resistant bacilli before hospitalization is accomplished."

Although these products may be used by non-VA hospitals, VA medical officials pointed out that "information to date indicates that the use of these drugs should be limited to patients who are clinically or bacteriologically resistant to streptomycin and that their daily dosage should not exceed 150 mg. of the drug. It also appears that epilepsy and renal insufficiency are strong contra-indications to the use of these drugs."

SCIENTIFIC EXHIBITS

(Continued from page 795)

S–31 **MANAGEMENT OF INTRACTABLE PAIN**

D. A. Cleveland, M. D., and E. J. Kiefer, M. D., Veterans Administration Center, Wood, and Marquette University School of Medicine

Intractable pain is that pain which is not relieved by treatment of the cause, medical, physical, or psychotherapy, and which is incompatible with help and comfort. Selective surgical therapy gives very satisfactory results in the vast majority of such cases. Unilateral prefrontal lobotomy is a procedure of choice in terminal cases or when psychosis is a factor. Cordotomy, tractotomy, posterior root section, and sympathectomy, or a combination of one or more of these procedures, can be used satisfactorily in most instances. These procedures are demonstrated in the exhibit.

S–33 S–34 **COLUMBIA HOSPITAL STAFF, MILWAUKEE**

The exhibit is a graphic representation of certain aspects of work done by various staff members in their respective departments. In some, an attempt is made to summarize and simplify a fairly broad subject; in others a narrower field is covered in more detail. The following subject matter will be covered: "Diagnosis and Treatment of Extruded Intervertebral Disc in the Cervical Region," "The Diagnosis and Treatment of Trimalleolar Fractures," "'Rooming In' Procedures at Columbia Hospital," "Varieties of Biliary Calculi," "Differential Diagnosis of Jaundice," and "Special Stains in Tissue Diagnosis."

S–35 **THE ALLERGIC ASPECT OF RECURRENT VOMITING IN INFANTS**

B. B. Schoenkerman, M. D., Milwaukee

The exhibit will attempt to prove that the majority of instances of recurrent vomiting in infancy, heretofore labeled as cause unknown, is an allergic response to protein in the infant's diet. In the past a great deal of formula juggling was the rule. The formula was too rich or contained too much fat. We feel that the formula is still responsible, however, the fault lies with the protein, one or several of which may offend.

S–36 **REGIONAL ANESTHESIA IN GENERAL PRACTICE**

L. G. Kilpatrick, M. D., University of Wisconsin Medical School

The display will consist of a series of diagrams and photographs illustrating, in a step-by-step manner, the performance of nerve-blocks which are likely to be of use to the general practitioner. The diagrams will also illustrate the sterilization and care of equipment, the preparation of local anesthetic solutions, and the complications of local anesthesia and their treatment.

S–37 S–38 **DIAGNOSIS AND THERAPY OF PULMONARY TUBERCULOSIS**

Wisconsin Anti-Tuberculosis Association

One part of the exhibit is planned to demonstrate the fact that "Any Patient May Have T.B." through the use of the chest x-ray film, tuberculin test, and sputum examination. The other portion of the exhibit is planned on "Treatment of Pulmonary Tuberculosis" by use of chemotherapy, surgery, and sanatorium care (In cooperation with a portion of a research program of the Wisconsin General Hospital). This exhibit will include a brief history, chest x-ray films, and pictures of gross and microscopic specimens.

ROUND TABLE AND DINNER RESERVATION

STATE MEDICAL SOCIETY of WISCONSIN — Annual Meeting

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ATTENDANCE LIMITED, SO LIST ALTERNATE CHOICES OF LUNCHEONS ON DAYS YOU WILL ATTEND . . . DINNER LIMIT IS 500

[PRICE OF EACH LUNCHEON: $2.50]

I Wish to Attend One of These Luncheons in the Order Given

MONDAY, OCTOBER 6:

	Number of Luncheon	Leader
1st Choice	_____	_____
2nd Choice	_____	_____
3rd Choice	_____	_____

TUESDAY, OCTOBER 7:

	Number of Luncheon	Leader
1st Choice	_____	_____
2nd Choice	_____	_____
3rd Choice	_____	_____

WEDNESDAY, OCTOBER 8:

	Number of Luncheon	Leader
1st Choice	_____	_____
2nd Choice	_____	_____
3rd Choice	_____	_____

[Make Check Payable to "State Medical Society of Wisconsin"]

ANNUAL DINNER, TUESDAY, OCTOBER 7

Number of reservations ($4.50 per plate) _____

Signed _____
(Print Please)

Address _____

City _____

Clinicopathologic Conference

Editors—W. A. D. ANDERSON, M. A., M. D., Marquette University School of Medicine, Milwaukee and D. M. ANGEVINE, M. D., University of Wisconsin Medical School, Madison

PRESENTATION OF CASE*

J. K., a 63 year old white male, became ill in November 1949. He had recently returned to Milwaukee from a trip to Greece. He complained of fatigue, night sweats, weight loss, and anorexia.

The principal physical findings on hospitalization were as follows: splenomegaly and a smooth non-tender enlarged (to the umbilicus) liver. The urine was normal. The red blood cell count was 2,880,000; reticulocyte count, 3.3 per cent; platelet count 382,000. The white blood cell count was 2,800 with a normal differential count. Gastric analysis revealed no free acid after histamine; no occult blood was found in repeated stool examinations. No parasites or ova were found in the stool. Blood culture and agglutination studies were negative. X-ray studies of the entire gastrointestinal tract were normal on two occasions. Chest films revealed basilar atelectasis. An electrocardiogram was read to show findings compatible with coronary insufficiency. Blood urea nitrogen, nonprotein nitrogen, serum bilirubin, and Van den Bergh tests were normal. Bromsulfalein and Hanger's flocculation tests were normal. Prothrombin concentration was 52 per cent. The Coomb's test was negative. Two attempts at bone marrow study were unsatisfactory, although cell morphology was reported as normal. The patient was given 6 units of whole blood and 50 r radiation to the spleen anteriorly and posteriorly. He was discharged with a tentative diagnosis of Hodgkin's disease.

In July 1951, the patient was admitted to the hospital with aggravation of the initial complaint. He had lost a total of 30 pounds in weight since the onset of illness. Recently shaking spells had developed that lasted 20 to 30 minutes. They were accompanied by no prodromal symptoms and were followed by no sequelae. The systemic review was negative. The patient used wine moderately and no tobacco.

Physical examination revealed pronounced weakness and marked cachexia. Hydration and turgor of the skin were poor. The lungs were clear to percussion and auscultation. There was an aortic systolic murmur. The liver edge was smooth and palpated 4 fingerbreadths below the rib margins on the right. The spleen was not palpated. No other abdominal masses or viscera were felt. The extremities were thin. The reflexes were physiological. Visual fields and fundi were normal.

Laboratory data was extensive. The red blood cell count was 3,150,000; hemoglobin 9 Gm.; the white blood cell and differential counts were normal. Nonprotein nitrogen was 46 mg.; blood urea nitrogen 19.8 mg.; creatinine 1.0 mg.; calcium 8.5 mg.; and phosphorus 4.8 mg. The urine was clear and amber with a trace of albumin and occasional red and white blood cells. Repeated blood smears for malaria were negative. No parasites or ova were found in several stool specimens. Skin test for Echinococcus was negative. Bone marrow was highly cellular. Red and white blood cell maturation appeared normal. No abnormal cells or malaria parasites were found in sternal marrow smears. Spinal fluid was clear; protein 80 mg.; no white blood cells and two red blood cells were found. Colloidal gold was 0000000000.

Chest films showed slight cardiac enlargement, mild congestion in the lungs, and no pleural fluid. Flat plate of the abdomen showed considerable enlargement of the liver. Kidney shadows were the same on both sides. No bone pathology was seen. Gastrointestinal series revealed normal esophagus, displacement to the left of the stomach by an enlarged liver, and flattened gastric mucosa consistent with atrophic gastritis. The skull revealed a normal sella turcica and no bone lesions. On intravenous pyelogram, the dye appeared on both sides with no apparent impairment of function. The kidneys were not outlined sufficiently for conclusive diagnosis; however, no obstruction or hydronephrosis was apparent (retrograde pyelogram studies were recommended).

The patient ran a febrile course with a daily peak of 103° F. He was given nitrogen mustard for four days with no change. Fifteen milligrams of ACTH every six hours for ten days brought subjective improvement with increased appetite, feeling of well-being, and gain in weight. One hundred milligrams of cortisone were then given with similar results. The patient gained a total of 10 pounds, but was soon back to his original weight of approximately 105 pounds. Quinine was given, and the temperature fell to within normal limits. Several blood transfusions were given as supportive therapy. Following one transfusion of whole blood, urticaria developed which was relieved by benadryl.

In September 1951, the improved condition of the patient made exploratory laparotomy possible. An enlarged spleen (225 Gm.) surrounded by fibrous adhesions was removed. The pathologic diagnosis was congestive splenomegaly with hemosiderosis and fibrosis. Immediate postoperative course was fair. On the fourth postoperative day, however, the patient became restless and unresponsive. Respirations

*From the Department of Pathology, St. Joseph's Hospital and Marquette University School of Medicine, Milwaukee; **Dr. M. C. F. Lindert and Dr. Samuel Rosenthal**, clinicians; and **Dr. D. J. Carlson**, pathologist.

became rapid and shallow and rales were heard throughout the chest. Heart activity became irregular, and the blood pressure fell. The patient expired on the fifth postoperative day.

Dr. D. J. Carlson: The spleen removed at surgery weighed 225 Gm. measuring 14 by 8.5 by 4.5 cm. It was covered with adhesions and the capsule was thickened. The cut surface was smooth, meaty, and deep reddish-brown. Along one edge several cysts, 1 to 2 mm. in diameter, were seen. Microscopic sections showed thickening and fibrosis of Billroth cords with intense congestion of the sinusoids. Follicles were small and inactive. Deposition of finely granular brown pigment was abundant and diffuse. The small cyst spaces were lined by flattened cells and filled with eosinophilic homogeneous material. Diagnosis was congestive splenomegaly with hemosiderosis, fibrosis, and lymphangiectasia.

Clinical Discussion

Dr. M. C. F. Lindert: The patient was certainly well studied in every respect, and there is very little additional work that could have been done. One should approach diagnostic problems with the positive findings. However, in this case, an overwhelming amount of negative findings was present, and these can be used to help rule out various disease processes.

The principal positive findings are hepatomegaly, splenomegaly, anemia, and fever. This particular clinical syndrome immediately suggests a fairly definite differential diagnosis. First and foremost this could be portal cirrhosis; however, fever is not prominent in portal cirrhosis. In fact, it has been overemphasized. One should not assume that in a patient with all the compatible findings of portal cirrhosis, the fever can be explained in this way alone. The converse is true. It is not due to cirrhosis until all other possible etiologic causes for obscure fever have been excluded. Splenomegaly in portal cirrhosis is very common. An enlarged spleen in the presence of hepatomegaly suggests portal hypertension, the principal cause of which is portal cirrhosis.

Does this patient have portal cirrhosis? There are many things that militate against this diagnosis, although the general picture is that of cirrhosis. The patient had relatively normal liver function tests. The normal serum bilirubin, the negative Hanger's flocculation, the normal thymol turbidity test, and the absence of clinical icterus make cirrhosis a remote possibility.

Next in importance is heart disease. Some claim that cardiac disease is the most common cause for combined liver and spleen enlargement. In my experience this has not been true. The spleen is, of course, enlarged in the course of congestive heart failure. It is also large in complicated cardiac disease, *i.e.* acute or subacute bacterial endocarditis. These last two diseases are highly probable in this case. The patient had heart murmurs; he was anemic; and the heart and spleen were enlarged. Bacterial endocarditis was entertained by attending physicians and at least one blood culture was negative. One negative blood culture, however, does not exclude bacterial endocarditis. Repetitious blood cultures should be done at various times during the patient's illness. However, I do not feel that bacterial endocarditis was present. Petechial phenomena were not present, and the clinical picture did not follow the usual retrogressive course of acute or subacute bacterial endocarditis.

The possibility of blood disease is next. Blood diseases are always brought to mind with splenomegaly. The possibility of leukemia was studied very thoroughly, but perfectly normal bone marrows make this a remote possibility. One must, however, remember that peripheral blood studies alone are not enough to rule out leukemia. In aleukemic leukemia, the peripheral blood may not suggest the diagnosis. For this reason, in the presence of obscure fever, splenomegaly, leukopenia, and a progressive retrogressive course, bone marrow studies should be done.

The lymphomas, to include Hodgkin's disease, Hodgkin's sarcoma, reticulum cell sarcoma, and lymphosarcoma, are next to be considered. The clinical picture was such that several independent clinicians felt that Hodgkin's disease was the best possibility. With all other things negative certainly a lymphomatous disease must be given very serious consideration. Some of you will wonder why lymph node enlargement was absent. This is not a requisite in the lymphomas. These diseases will manifest themselves in several ways. For example, Hodgkin's disease may be localized to the mediastinum, spleen, or abdominal lymph nodes. True, it would have been very helpful if the patient had had disseminated lymph node enlargement and a gland had been removed from the supraclavicular or axillary areas. The pathologist would probably have made the diagnosis for the attending physicians.

Could this be carcinoma? One cannot discount the possibility of hidden malignancy; and it was entertained by the clinicians. They made a concerted effort to look at all areas for primary tumor. This included mediastinum, lungs, entire gastrointestinal tract, kidneys, ureters, and the urinary bladder. On repetitious study, malignancy was not found.

Not finding carcinoma in the gastrointestinal tract should not lead one to discount its possibility. Roentgenology is not foolproof. There are several types which are notoriously hidden. For example, very small or intramural carcinoma of the stomach (linitis plastica) may exist even with massive metastatic spread of the tumor. The small intestine is also extremly difficult to investigate. Even with multiple balloon studies, small lesions of the small intestine may be missed. Many physicians sit back with false assurance in the presence of negative

barium enema studies. The adjunct study of roentgenology is many times less helpful than the examining finger and proctosigmoidoscopic examination of the rectum. Right-sided lesions of the cecum or ascending colon can certainly be missed. A recent study showed that in 60 per cent of patients studied on three separate occasions lesions of the cecum and ascending colon were missed. The reason is primarily because the cecum is a large, easily dilated structure; a lesion can protrude into that area without visualization. This is unfortunate, because right-sided lesions are very amenable to surgery. Another notable site is the pancreas. Roentgenology helps very little in the diagnosis of carcinoma of the pancreas. Any of the above malignancies most certainly cannot be completely ruled out in this case even though no primary site was found. This could also be primary carcinoma of the liver. In carcinoma of the liver, there is usually rather extensive right lobular enlargement. Jaundice may or may not be found. Ascites is most frequent, and the disease is frequently confused with portal cirrhosis. These patients also have fever. However, splenomegaly is uncommon. Carcinoma of the kidney should not be overlooked.

Hidden abscesses in the body are associated with splenomegaly. Enlargement of the liver, however, does not fit in this case. Amebic abscesses would certainly be a possibility in a patient who has been to Greece and, of course, an Echinococcus cyst. No amoeba or cysts were found in repeated stool examinations. Skin tests for Echinococcus were negative and eosinophilia was absent. We cannot eliminate tuberculosis; but tuberculosis involving liver and spleen is most unusual especially in the absence of pulmonary tuberculosis. Syphilis is apparently ruled out by repeated negative blood and spinal fluid serology. Everyone must have felt that malaria was a possibility. The patient had numerous negative blood and sternal marrow smears. Even though he responded to quinine, I believe that malaria is a remote possibility.

I personally feel that the clinicians were always on the right track. Some form of lymphomatous disease existed in this patient. I would like to call it a localized Hodgkin's sarcoma involving primarily the abdominal structures, *i.e.* liver and spleen. A second choice or alternate diagnosis is hidden malignancy, most likely within the pancreas.

Necropsy Findings

Dr. D. J. Carlson: The body was emaciated. The skin and sclerae showed slight icteric discoloration. A recent T-shaped incision was present in the left upper abdomen. One hundred milliliters of clear yellow fluid were present in the left thorax. One hundred and fifty milliliters of similar fluid were found in the pericardial sac. The abdominal cavity contained no fluid. Normal anatomical relationships within the abdomen were preserved except for adherence of omentum to the undersurface of the abdominal incision, and the spleen was absent. The heart weighed 400 Gm. There was edema of subepicardial fat. The cardiac muscle was red and of average thickness. Minimal thickening of aortic and mitral valve cusps was noted. Coronary vessels were elastic and widely patent. The lungs weighed 400 and 500 Gm. respectively. There was slight emphysema of the apices and atelectasis in the bases. The bronchi contained yellow-green exudate; the mucosa was reddened. The liver weighed 2,400 Gm. It was deep bluish-red on external and cut surface. The capsule showed focal cloudiness and thickening; the edges were rounded. The pancreas was lobulated, gray-tan, and firm. The splenic artery contained an adherent thrombus. The adrenal glands were of average size, shape, and appearance.

The right kidney weighed 240 Gm.; the surface was smooth and red. Parenchymal markings were distinct. Two small 1 cm. retention cysts were present. The left kidney weighed 840 Gm., measuring 16 by 9 by 6 cm. A large tumor mass distorted the normal contour. This tumor mass was covered by a thin capsule and was lobulated. The cut surface was yellow and red with focal areas of necrosis and cyst formation. A yellow tumor thrombus filled the left renal vein and extended into the inferior vena cava for a distance of 4 cm. The bladder and prostate were not remarkable. No significant lesions were found within the esophagus, stomach, or small and large intestine.

On microscopic examination, the important findings were in the sections of the left kidney. The tumor was composed of large polyhedral cells arranged in strands, cords, and alveolar structures. Cell cytoplasm was clear. Nuclei were compact, central in location with prominent nucleoli. Hyperchromatism and mitotic figures were prominent and numerous. Several areas of necrosis were seen. There was compression of surrounding renal tissue. The remaining kidney tissue was not unusual except for vascular congestion and minimal nephrosclerosis.

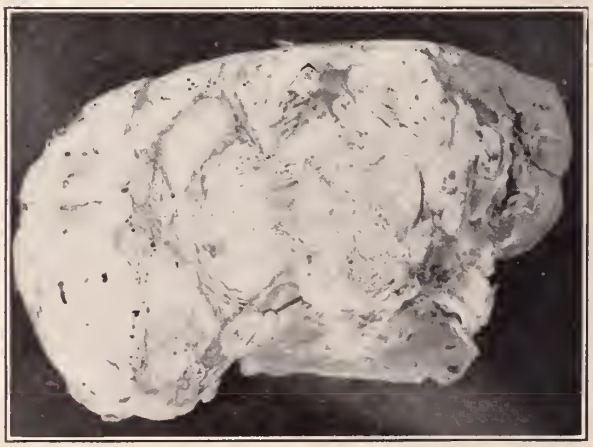


Fig. 1.—Left kidney with carcinoma (hypernephroma).

The autopsy diagnosis was clear-cell carcinoma of the left kidney (hypernephroma), tumor thrombus of the left renal vein and inferior vena cava, myocardial fibrosis, interstitial nephritis of left kidney, and pulmonary atelectasis.

Discussion

Dr. Samuel Rosenthal: In self-defense I want to add that I was never convinced that this patient had Hodgkin's disease. When he first came to this hospital, we did consider hypernephroma a strong possibility for the following reasons:

(1) It is a well established fact that of all the malignant tumors which produce fever, hypernephroma is a common one.

(2) The kidneys were the only organs that had not been x-rayed when the patient was studied very thoroughly by competent men elsewhere.

It was because of this possibility of hypernephroma that an intravenous pyelogram was done. At the time it was interpreted, I looked at the films with Doctor Sengpiel, our radiologist, and we discussed the possibility of a hypernephroma. Doctor Sengpiel felt that the films showed no enlargement of the kidneys, but that they were unsatisfactory in so far as making a conclusive diagnosis. I think we were lulled into a false security by the fact that the intravenous pyelograms showed no unusual enlargement and the function was good on both sides.

Another possible factor which veered us away from the hypernephroma was the state of mind described as autohypnosis, where a physician sees a patient who has been previously studied extensively by competent men and knows their diagnosis or is aware of the fact that after exhaustive study they are still uncertain. Because of the previous uncertainty, one is very prone to conclude that the disease is most likely very unusual or rare, for were it common, it would have been found by the previous doctor. In this case, there were two facts which influenced me in this particular respect. One, there had been uncertainty on the part of the previous doctors after exhaustive study. Two, there was a history that the illness had appeared after a trip to Greece where we know exotic diseases such as malaria and infestation with Echinococcus are not uncommon as compared to the diseases prevalent in this area.

While in the back of my mind there was the thought that this was perhaps an unusual form of Hodgkin's disease which I had never encountered, my reasons for feeling that it was not Hodgkin's were the following:

(1) The patient had been ill for two years, and yet there was no evidence of enlargement of the mediastinal glands or peripheral glands.

(2) Hodgkin's and the other lymphomas are usually multicentric diseases, especially after a two year period.

(3) Radiation therapy, even in the small amount given, usually produces some improvement and here there had been none.

(4) A therapeutic test with nitrogen mustard was also entirely negative.

I have the feeling that had this patient not gone to Greece, we would have made the diagnosis because we would have focused our attention on common diseases causing obscure fever over long periods of time, and with the exclusion of lymphomas, sepsis, and other neoplasms causing fever, the hypernephroma would have ultimately been found.

Question: What were the indications for laparotomy?

Doctor Rosenthal: The principal reason was diagnosis. All efforts to certainly establish diagnosis by medical means were unsuccessful. Then too, with the diagnosis of Hodgkin's disease, this could well have been hypersplenism secondary to Hodgkin's disease of the spleen. I felt, and still do, that the patient did have hypersplenism although it was quite mild.

You can now ask the embarrassing but pertinent question. Why did we not feel the enlarged kidney with the abdomen open? We should have felt it, but did not. The stomach, entire large and small intestine, pancreas, and retroperitoneal spaces were palpated. However, again, an enlarged spleen bound down by numerous adhesions pushed us further away from the truth as did our mental attitude in thinking the patient suffered from a rare disease which we might not find. This is a good example of why physicians should be humble in diagnosis. We learn from those cases we miss, and when we make a correct diagnosis, it behooves all not to assume a smug, complacent air like the cat that caught the canary.

Question: Should any significance be attached to the finding of a few red cells in the urine? Why was the renal mass not felt on palpation of the abdomen prior to surgery?

Doctor Rosenthal: We noticed the urine red cells; however, in a man with coincident heart disease, specifically congestive failure, red cells may be found in urine. Moreover, the diagnosis of hypernephroma of the kidney on a few red and white blood cells in the urine is most hazardous and without foundation. Concerning the palpation of the mass, no one felt it. I, other clinicians, interns, and residents palpated the patient's abdomen many times, and no one felt or palpated an enlarged kidney. Again I think autohypnosis was the reason.

Doctor Lettenberger: There are many cases of Hodgkin's disease in the literature that simulate this case very closely. With the clinical picture presented here, the diagnosis of Hodgkin's disease is most logical.

Lake Tomahawk State Camp "A Rehabilitation Center"

As It Looks to the State Board of Health

WISCONSIN, through its Board of Health, operates the only facility in the state devoted to the rehabilitation of individuals who have completed their cure of tuberculosis and yet are not ready for full-time employment. The facility, Lake Tomahawk State Camp, is located in the forests of northern Wisconsin. Its services are available to persons who are convalescing from tuberculosis. Their disease must be classified as inactive, according to the diagnostic standards and classification of tuberculosis.

The camp was established early in 1915 as a place where men could complete their cure of tuberculosis, build themselves up physically, and earn their maintenance by working in the forests of northern Wisconsin. Shortly after the camp opened, it was found that this original plan would not work; men who have had tuberculosis could not be expected to follow the rigorous life of lumberjacks, and the work activity was soon changed to something much lighter. There was a gradual change in the planned activities to the point where today both men and women work toward a vocational objective of their own choice, yet suitable as far as their physical condition, educational background, aptitudes, and interests indicate.

The work activity is jointly planned by the individual, the vocational counsellor, and the physician. The hours of physical activity are prescribed by the medical director, a tuberculosis specialist, who considers each individual plan when he reviews the x-rays and makes his monthly physical examination.

The plan to combine physical well-being and vocational training or experience is done on the basis of starting an individual on a one hour per day prescribed work schedule; this is gradually increased under medical supervision to the point where the individual works eight hours per day if possible. The work activity includes one hour per day of camp duties prescribed particularly to keep the individual active and keep his body in tone. The balance of the prescribed time is used in vocational training, on-the-job training, or actual work experience.

The individuals who have had no work experience are given psychological tests to determine their interests and aptitudes. Those who must change their job objective because their previous work is not suitable for individuals who have had tuberculosis receive help in selecting a suitable objective. The person who expects to return to a former occupation is helped by locating work in his particular field wherever possible. All this again is done on a physically graduated basis.

The training is provided through a neighboring vocational school, by neighboring high schools, and the unusual cooperation of the business men in the locality who provide on-the-job training in many individual fields, such as telephone switchboard repair, movie projection, photographic laboratory work, automobile ignition repair, and the like. The on-the-job training is done without compensation at first, and primarily on a training basis. However, experience has proven that many business men retain those they have trained in their own business when the individual is medically discharged from the camp.

This medically recommended, graduated work program gives each individual an opportunity to prove to himself and others that he is capable of working a full eight-hour day if possible without injury to himself. It, too, gives the ex-patient an opportunity to return to his home community free from the worry that he will not be accepted because he has had tuberculosis. The camp experience automatically makes him accustomed to working with others and the general public, losing consciousness of the fact that he has had tuberculosis.

All patients come to the rehabilitation center of their own volition. They must be recommended by their sanatorium physician who in turn reports to the camp medical director. If the program seems feasible for the individual, it is furnished to him without charge by the state which finances the program jointly with the county in which the individual has residence. The Lake Tomahawk State Camp rehabilitates approximately 120 individuals each year.—Mr. Leonard Heise, *Camp Director and Counselor.*

AMERICAN COLLEGE OF SURGEONS TO MEET IN NEW YORK CITY

New surgical techniques and clinical developments will be presented at the thirty-eighth annual Clinical Congress of the American College of Surgeons to be held in New York City September 22 to 26. The program will include panel discussions, symposia, surgical forums, motion pictures, cine clinics, color television, and exhibits. Headquarters will be at The Waldorf–Astoria.

For further information address the American College of Surgeons, 40 East Erie Street, Chicago 11, Illinois.

. . . . THE PRESIDENT'S PAGE . . . .

Those I-A Notices

THE fact that 638 Wisconsin doctors are getting I-A notices from their local draft boards has caused a lot of concern.

That is understandable. Many of these physicians are between 40 and 50 years of age and have large families and business responsibilities. Offhand, they find it hard to understand why a Korean situation, which the government considers a "police action," should cause such a drain on civilian medical men.

Everyone wants to know what this is all about. Here is what is happening.

Since November 1950, more than 200 Wisconsin physicians in Priorities I and II have been commissioned or placed on active duty with the Armed Forces. Some of these are now getting out of service. It is expected that the supply of available physicians in these two priorities will be exhausted by next spring or summer. The next physicians in line are those in Priority III.

The Defense Department says Priority III physicians are needed to replace officers getting out of service and to keep up with the Korean war and the mobilization picture. Of course, no one can predict the effect of the coming elections or changing world situations.

Anticipating the possibility of needing more physicians by next summer, National Selective Service headquarters has ordered all local draft boards to classify and give physical examinations to all Priority III physicians. The doctor must be classified I-A before he can be ordered to physical examination. That is why so many doctors recently received I-A notices.

If the physician fails to pass the physical, he is automatically eliminated from further consideration. If he does pass, his local board *will then wait* for a recommendation on his essentiality—a recommendation which is made by the Wisconsin Advisory Committee to Selective Service. The local boards will then reopen the cases of all physicians who passed their physical examinations. The physicians' appeal rights are preserved until after this reconsideration.

A deferment for dependency will be granted only if the doctor's induction will cause "extreme hardship and privation" to a wife, child or parent with whom he maintains a bona fide family relationship in his home.

Not all the ground rules have been laid down for processing Priority III doctors, but it looks as if the younger men will be taken first. Physicians above the age of 44, with considerable civilian practice, would have to be commissioned in grades of Major and above. The Armed Forces are not too eager to get men in the high pay grades if there are younger men available.

Albin T. Heidner M.D.

COMMITTEE *Concentrates*

Because of vacations, the preparation of committee reports for the House of Delegates, and work in connection with the Annual Meeting, the number of committee meetings have been held to a minimum. Only such meetings are held as are required to handle special problems which arise.

CLAIMS COMMITTEE JULY 2

MDs Present: John Sprague, N. A. Hill.

As usual the primary purpose of the meeting was to settle claims and to continue the work being done to develop a master fee schedule to be used in the office for the payment of unlisted claims.

MATERNAL MORTALITY COMMITTEE Sub Committee on Maternal and Child Welfare JULY 10

MDs Present: L. M. Simonson, John Harris, Thomas Leonard, Amy Louise Hunter, Carl Neidhold

Reviewed suggestions for modification of recommended program by Minnesota physicians closely identified with mortality study in that state. Recommended to Committee on Maternal and Child Welfare that (1) Study Committee be composed of not more than six physicians, located close enough to Madison for periodic meetings, (2) "Interviewers" to assist Study Committee be selected from panel of obstetricians, chosen by the chairman of the Committee on Maternal and Child Welfare, (3) Hospitals, all doctors, and other interested parties be informed as to the program prior to January 1, 1953, and (4) The entire program be under the direction of the Committee on Maternal and Child Welfare, with financial assistance from the Bureau of Maternal and Child Health of the State Board of Health.

CONFERENCE COMMITTEE ON OPEN PANELS OF THE COUNCIL ON MEDICAL SERVICE JULY 16

MDs Present: David Goldstein, Bruce Brewer, and D. M. Willison (as well as two insurance representatives, Mr. Harry Nelson, director of Workmen's Compensation, and Mr. Mortimer Levitan, assistant attorney general)

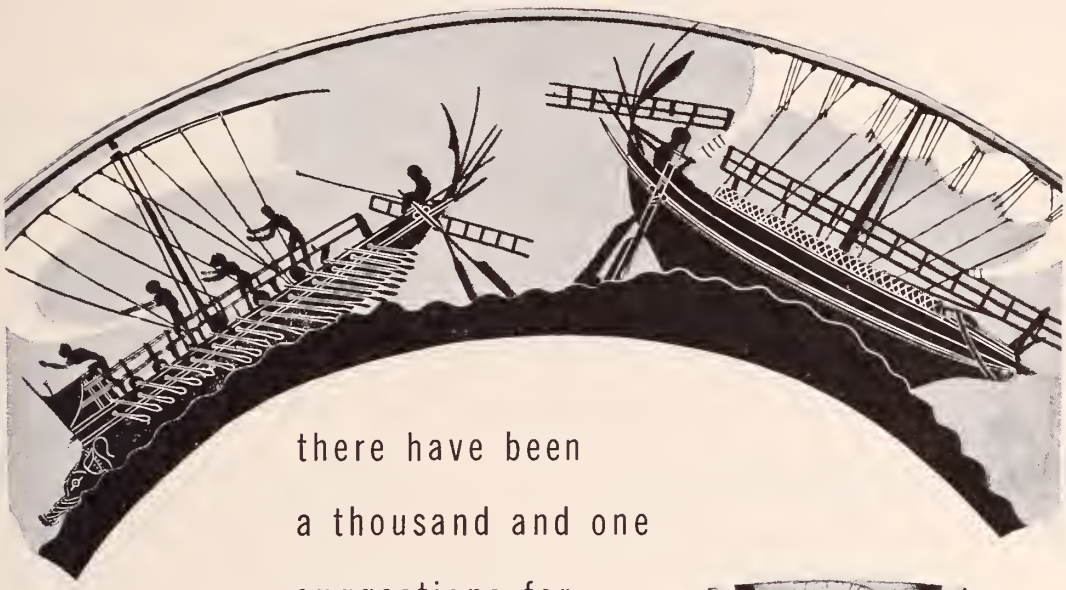
Purpose of meeting to review case involving an orthopedic surgeon, who attended at the request of the committee. The case involved a complaint of the State of Wisconsin. The committee reviewed the charges, and adjusted the bill. The committee also recommended that insurance carriers print on the back of the Surgeon's First Report a graph of the hand and foot, so as to facilitate the reporting of amputations.

INTERIM COMMITTEE JULY 24

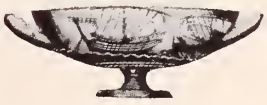
MDs Present: John Bell, A. H. Heidner, R. G. Arveson, S. E. Gavin, A. J. McCarey, Roman Galasinski, J. C. Griffith

Recommended to the Council: that certain committees of the State Society be combined in a Council on State Departments, to provide better co-ordination of committee activities in fields related to work of the Department of Public Welfare, the Department of Public Instruction, and the State Board of Health . . . . that study be given to the Interim Committee being changed to an Executive Committee of the Council, as a means of clarifying its legal status . . . that the Council authorize the purchase of additional property so as to facilitate the building of quarters needed to properly house the growing activities of the State Medical Society . . . . that thought be given to the possible acquisition of the Fort Crawford Military Hospital, in Prairie du Chien, to serve as a medical shrine, and to be operated and maintained in cooperation with the State Historical Society . . . . that the 1953 Blue Book issue of the Medical Journal feature a section called "Who's Who In the Health Field in Wisconsin" to outline the organization and functions of such agencies as the Cancer Society, the Heart Association, and other health organizations . . . . that study be directed to the Sections in relation to the House of Delegates . . . . that a by-law be

Ever since man went down
to the sea in ships



there have been
a thousand and one
suggestions for
the relief of
motion sickness.



War ship and merchant ship, about 500 B. C., from painted vase found at Vulci in Etruria, now in the British Museum.

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introduced at the 1952 Annual Meeting which would provide that a quorum of the House of Delegates must be one-fourth of the members of the House and that such one-fourth must represent also one-fourth of the county medical societies in the state . . . . that efforts be made to have the Continuation Center at the University of Wisconsin located outside of the highly congested area where it is scheduled to be built . . . . that the physicians appointed to membership of Associated Hospital Service Inc. be approved. They are: R. F. Schoen, Beaver Dam; A. W. Hilker, Eau Claire; H. E. Cook, D. M. Willson, G. F. Kelly, A. D. Kilian, and Edward Eisenberg, Milwaukee; W. J. Fencil, Monroe; and R. E. Schrank, Waupun . . . . that from this point on the practice of furnishing free dinners to members of the "50 Year Club" and their wives, at the Annual Dinner, be discontinued in view of the large number of members involved.

COUNCIL JULY 25–26

MDs Present: A. H. Heidner, J. C. Griffith, H. Kent Tenney, W. D. Stovall, F. L. Weston, R. G. Arveson, W. H. Costello, T. C. Hemmingsen, H. E. Kasten, E. M. Dessloch, A. J. McCarey, J. M. Bell, E. E. Kidder, V. E. Ekblad, R. E. Galasinski, E. L. Bernhart, N. J. Wegmann, C. E. Zellmer, S. E. Gavin, C. N. Neupert, Gunnar Gundersen.

Doctor Dessloch presented a detailed report for the Commission on Prepaid Plans of its activities in direction of Wisconsin Physicians Service and the Wisconsin Plan during the second quarter of 1952, and the Council approved that report . . . The Council approved the recommendations of the Interim Committee . . . . Roy Ragatz, assistant secretary, and Ray Hoops, comptroller for the Society, were featured in a round-table discussion of their activities with the Society . . .

COMMITTEE ON MILITARY MEDICAL SERVICE JULY 30

MDs Present: F. L. Weston, O. G. Moland, J. M. Sullivan, M. J. Musser, M. H. Steen.

This committee advises the Wisconsin Advisory Committee to Selective Service and the Armed Forces Reserves as to the essentiality of physicians. Physicians in Priority I and II who have been recommended as "essential" heretofore were reviewed to determine whether this recommendation is to continue. At the same time, the committee was informed that 635 Priority III physicians are to be processed within the next month and plans were made for obtaining recommendations as to their availability or essentiality.

RELATED ACTIVITIES

July 1: *W.A.T.A. Consultation Service Planning Committee*: representatives of staff and Committee on T.B. and Chest met with W.A.T.A. medical director, representatives of the U. of W., State Board of Health, Trustees Association, and others to discuss proposed discontinuation of consultation service of W.A.T.A. as routine procedure and substitution of other types of educational services, or demonstrations such as routine x-ray examination of hospital admissions. Recommendations and explanation of new program will be forthcoming in *Journal* and elsewhere . . . . July 2 *Executive Committee of Public Health Council* met and discussed methods of expanding the scope of community health councils and making their work more vital, so as to have a wider appeal for membership and the development of programs. Named a nominating committee to select nominees for offices to be filled for 1953. Members are Susan Norman, R. N., Chairman, Milwaukee; A. H. Heidner, M. D. West Bend; and Mrs. David Anthony, Brooklyn . . . . July 8 *Industrial Health Committee of Medical Society of Milwaukee County* met with asst. secy. of SMS to discuss plans for 1953 clinic, which will concentrate on rehabilitation.

AMERICAN ASSOCIATION OF BLOOD BANKS TO MEET IN MILWAUKEE

The American Association of Blood Banks will hold its fifth Annual Meeting at the Hotel Schroeder in Milwaukee, October 9, 10, and 11. All those concerned with blood banking and blood transfusions will find this meeting of great interest. A refresher course for blood bank technicians will be given. Individual registration fee for the convention is $5.00.

Further information may be obtained by writing to Mr. R. F. Ambelang, business manager, Junior League Blood Center of Milwaukee, Inc., 763 North Eighteenth Street, Milwaukee 3, Wisconsin.

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an agency of the State Medical Society of Wisconsin

Prepared by the Commission on Prepaid Plans of the State Medical Society of Wisconsin, E. M. Dessloch, Prairie du Chien, Chairman.

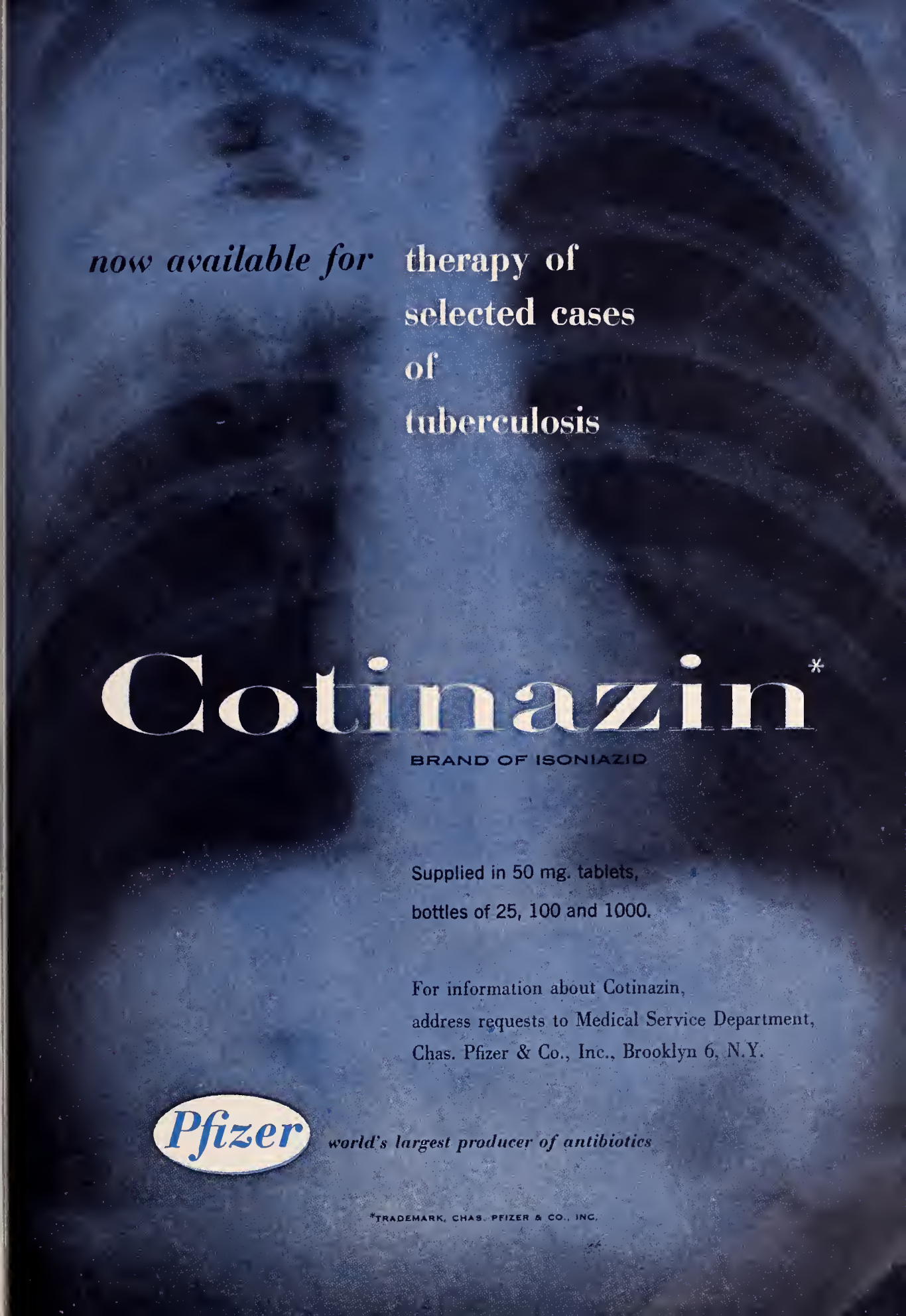
Benefits for Multiple and Multiple-Stage Procedures

Multiple and multiple-stage procedures performed for patients covered by Blue Shield are payable according to formulas established by the Commission on Prepaid Plans of the State Medical Society. It should be noted, however, that the formulas below are superseded by the Schedule of Benefits if an amount has been fixed for the procedures. Examples of the latter are tonsillectomy and adenoidectomy, D and C, and ureteral transplant and cystectomy. These formulas are also printed on page 12 of the Schedule of Benefits (brown cover).

The following formulas govern benefits payable for multiple and multiple-stage procedures under the new "A" and "B" program only:

Situation	Formula
1. Where more than one procedure done through the same incision during the same anesthesia period,	Pay only benefit assigned major procedure. (Example—cholecystectomy-appendectomy. Pay cholecystectomy.)
2. Where more than one incision is made during same anesthesia period and in the same general body cavity (abdomino-pelvic; chest, cranial),	Pay benefit assigned major procedure.
3. Where there are multiple procedures, related or unrelated, not governed by rules #1 and #2, but are during same anesthesia period,	Pay the highest benefit in the schedule plus 50% of each of the other procedures with a total limitation of $500. *(Example:* abdominal hysterectomy and perineorrhaphy. Pay 100% hysterectomy and 50% of listed fee for perineorrhaphy.) Because many procedures performed under this rule are not listed in the Schedule of Benefits, physicians are requested to list the procedures performed and some details as to extensiveness.
4. Where more than one procedure is performed during different periods of anesthesia, but these are related to same sickness or accident, and during same period of hospitalization or disability,	Pay benefits for each procedure. Total limitation of $700.
5. Where more than one procedure is performed during different periods of anesthesia and while related to the same sickness or accident, and there has been complete recovery from the earlier procedure,	Pay benefits assigned each procedure.
6. Where more than one procedure is performed during different anesthesia periods, but are not related to the same accident or sickness,	Pay benefits assigned each procedure.

Physicians reporting multiple or multiple-stage procedures are urged to list each procedure performed and details concerning the extent and complexity of services rendered. This is particularly true in the case of multiple injuries. Because such multiple procedures are not specified in the Schedule of Benefits, a detailed listing of services rendered will enable the physicians on the Blue Shield claims committee to more accurately determine the benefit allowable.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Society Proceedings

Green Lake–Waushara

The last meeting of the Green Lake–Waushara County Medical Society was held on May 29 at the Silver Cryst Lodge on Silver Lake near Wautoma. A dinner, at which many local nurses and the wives of members were present, preceded the meeting.

The Society's business meeting was held at the summer home of *Dr. H. C. Koch*. *Dr. E. E. Kidder* of Stevens Point, councilor of the Ninth District, discussed the work of the Council.

Wisconsin Surgical Club

The Wisconsin Surgical Club met in Appleton on May 31 for one of their two annual sessions. The group holds one meeting each year with one of its members, and this year *Dr. V. F. Marshall* of Appleton was the host. The guest speaker was Dr. M. L. Mason, associate professor of surgery at Northwestern University Medical School, who spoke on "Extensive Crushing Injuries of the Hand."

The other speakers and their subjects were as follows: *Dr. W. S. Marshall*, Two Rivers, "Some Pathologic Aspects of Cutaneous Wound Healing;" *Dr. C. D. Neidhold*, Appleton, "The Diagnosis of Carcinoma of the Colon;" *Dr. H. T. Gross*, Appleton, "The Acute Gallbladder;" and Dr. V. F. Marshall, "Kaleidoscopic Review of 50 years of Surgery." Colored motion pictures on big game hunting in the Canadian Rockies were shown by *Dr. R. V. Landis* of Appleton.

Pictured above are members of the Wisconsin Surgical Club as they met at St. Elizabeth Hospital in Appleton. From left to right in the first row are Drs. T. J. Snodgrass, Janesville; M. L. Mason, the guest speaker; F. G. Connell, Oshkosh; F. A. Stratton, Milwaukee; S. E. Gavin, Fond du Lac; V. F. Marshall, Appleton; and E. R. Schmidt, Madison. Standing in the same order are Drs. W. S. Bump, Rhinelander; C. F. Conroy, Milwaukee; P. A. Midelfart, Eau Claire; Joseph Klug, Milwaukee; R. M. Kurten, Racine; and S. B. Gundersen, La Crosse.

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News Items and Personals

Doctor Foster to Take Postgraduate Work

Dr. T. D. Foster, Cornell, recently sold his practice and moved to Washington, D. C. He plans to take a three year course in obstetrics and gynecology at George Washington University School of Medicine. *Dr. B. F. Rahn*, who formerly was associated with *Dr. C. E. Zenner* in Cadott, will replace Doctor Foster in Cornell.

Appleton Doctor Elected to Pediatrics Academy

Dr. L. P. Williams, Appleton, was recently elected to fellowship in the American Academy of Pediatrics. The doctor who has practiced in Appleton since 1948 was a 1944 graduate of the University of Wisconsin Medical School. He served his internship at Milwaukee Hospital.

Dr. J. W. Koch Opens Office in Colby

Dr. J. W. Koch, Owen, recently took over the office and practice of the late Dr. A. L. Schemmer of Colby. Born in Butternut, the doctor graduated from the University of Wisconsin Medical School and served his internship at St. Joseph's Hospital in Marshfield. He is now on the staff of St. Joseph's Hospital and also the Victory Memorial Hospital at Stanley.

Sparta Clinic Has New Associate

The Sparta Clinic recently announced the appointment of a new member to its staff. He is Dr. R. P. Froeschle who came to the Clinic on July 9 after completing his internship at Milwaukee County General Hospital. The doctor is a graduate of the University of Illinois College of Medicine.

Doctor Magnin Joins Clinic Staff

Dr. George Magnin, who for the past three years has been a resident physician at the Wisconsin General Hospital in Madison, has joined the staff of the Marshfield Clinic. The doctor is a graduate of the University of Wisconsin Medical School and served his internship at Christ Hospital, Cincinnati. Prior to his residency, he was on active duty with the United States Navy.

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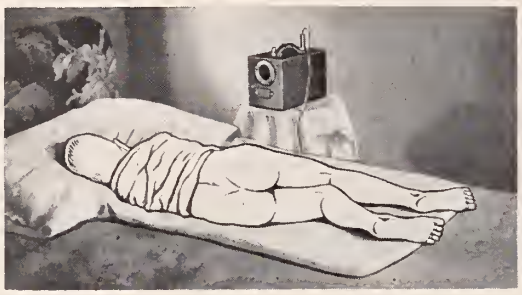

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THIRD AND TWELFTH DISTRICT NEWS

New Professors Appointed at U. W.

The regents of the University of Wisconsin recently approved the appointment of two new members of the staff of the Medical School. Dr. F. E. Shideman was appointed professor of pharmacology and toxicology. He will replace *Dr. O. S. Orth*, who has been transferred to the newly-created department of anesthesia.

The other appointment is that of Dr. Harry Waisman as associate professor of pediatrics for 1952–1953. Doctor Waisman has been on the staff of the University of Illinois College of Medicine.

Doctor Gordon Addresses Health Education Workshop

Dr. E. S. Gordon, associate professor of medicine at the University of Wisconsin, was the guest speaker on July 8 at a Health Education Workshop which was held at Oshkosh State College. Doctor Gordon chose as his subject "The Endocrine System in Relation to Emotional Problems."

Dr. A. L. Banyai Honored by National Group

Dr. Andrew L. Banyai, associate clinical professor of medicine at Marquette University School of Medicine, was installed as president of the American College of Chest Physicians when the College held its eighteenth annual meeting this June in Chicago. Another Wisconsin physician serving as an officer of the College is *Dr. Alfred A. Busse* of Jefferson who is a member of the Board of Governors.

Specialist Opens Practice in Milwaukee

Dr. Lyle W. Swartz, who was associated with the Johnson Rectal Clinic of Milwaukee from 1944 to 1952, opened an office in Milwaukee on July 1 and will specialize in rectal diseases. The doctor is a graduate of Marquette University School of Medicine and has devoted the past eight years to a preceptorship, assistant, and associate training with Doctors Johnson and Johnson of Milwaukee.

A paper by Doctor Swartz entitled "Incidence and Importance of Lesions Found in Routine Proctosigmoidoscopy" was published in the February issue of the *Wisconsin Medical Journal*.

Milwaukee Health Department Holds Instaff Training Program

The medical staff from the districts in the Milwaukee Health Department held their instaff meetings during the week of June 16–20. *Dr. E. R. Krumbiegel*, Commissioner of Health, reports that papers were presented at the meeting on the audiometric survey in Milwaukee public schools, the problems

of obesity and undernourishment in school children, the new approach to the posture problem, need for emphasis on vitamin D prophylaxis in all ages in childhood, better vocational planning for the cardiac child, and dental school health problems.

The papers discussed services to 108,000 school children and 10,786 children in the infant and preschool age group.

SOCIETY RECORDS

New Members

A. W. Burek, Wausau.

H. T. Callahan, Spencer.

D. J. Malloy, 8700 West Wisconsin Avenue, Milwaukee.

R. P. Wiesen, 2353 North Sixty-fourth Street, Milwaukee.

E. G. Clahassey, 1300 University Avenue, Madison.

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Changes in Address

J. J. Mulvaney, Winnebago, to 32 South Main Street, Clintonville.

G. E. McCormick, Redwood City, California, to 1411 Wauwatosa Avenue, Wauwatosa.

R. B. Leitschuh, Milwaukee, to 521 Maple Street, Waukesha.

R. A. Lehmer, Colby, to 806 West Church Street, Champaign, Illinois.

H. J. Kanin,* Milwaukee, to 273 Menlo Boulevard, San Antonio, Texas.

L. G. G. Glasson, Milwaukee, to 537 Northwest 23rd Place, Miami, Florida.

R. A. Flynn,* Sparta, to Camp McCoy.

Helen P. Davis, Phoenix, Arizona, to 1300 University Avenue, Madison.

J. C. Curry, Mt. Calvary, to 9322 West Mt. Vernon Avenue, Milwaukee.

D. A. Cofrin,* Chicago, Illinois, to 1105 South Jackson Street, Green Bay.

W. E. Archer, Tomah, to % M. D. Davis, 217 North Orchard Street, Madison.

C. M. Kelly,* La Crosse, to United States Naval Radio Station, Skaggs Island, Sanoma, California.

A. M. MacKay, Madison, to 1333 Rosewood Avenue, San Carlos, California.

D. H. Bruns, Milwaukee, to Box A, Camarillo, California.

H. H. Danaher, Milwaukee, to The Gosin Clinic, Minahan Building, Green Bay.

D. A. Gutheil, Wauwatosa, to Maple Crest Sanatorium, Whitelaw.

G. T. Hoffmann, Galveston, Texas, to 902 Grant Street, Madison.

R. D. Johnson, Benton Harbor, Michigan, to University Hospital, Ann Arbor, Michigan.

J. H. Juhl, Madison, to 604 Medical Arts Building, Minneapolis, Minnesota.

J. A. Junck, Sheboygan, to 3940 West Lisbon Avenue, Milwaukee.

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J. S. Stehlin, Milwaukee, to 74 Buckingham Street, Cambridge, Massachusetts.

D. H. White, Madison, to 5636 North Delaware Street, Indianapolis, Indiana.

F. G. Zeier, Milwaukee, to 1233 North Church Street, Rockford, Illinois.

R. W. Quinn, Madison, to Department of Public Health, Vanderbilt University, Nashville, Tennessee.

W. F. Brown, Madison, to 32 Hilburn, Rosendale, Massachusetts.

P. D. Anderson, La Crosse, to 8700 West Wisconsin Avenue, Milwaukee.

Tokuso Taniguchi,* Milwaukee, to 2114–1 Army Service Unit, United States Army Hospital, Camp Pickett, Virginia.

J. L. Teresi, Waukesha, to Route 1, Box 131, Saratoga, California.

J. F. Wepfer, Emporia, Kansas, to 6140 West Appleton Avenue, Milwaukee.

J. G. Frisch,* Bangor, Maine, to Medical Examination Course, USAF School of Aviation Medicine, Randolph Air Force Base, Texas.

Thomas L. Buhl, Torrance, California, to Wadsworth General Hospital, Los Angeles, California.

*Military service members.

DEATHS

Dr. Francis A. Malone, 74, Waterford physician, died on June 11 at his home following an illness of long duration. He was born in Waterford on March 6, 1878.

In 1900 the doctor entered the Milwaukee Medical College and was graduated from Northwestern University Medical School in 1904. He practiced medicine in Milwaukee for approximately three years before setting up his permanent practice in Waterford.

Upon his return to his native community, Doctor Malone and Drs. William Prouty and William Fulton established a small hospital in Burlington. Doctor Malone was president of the Burlington Memorial Hospital staff for many years, and for 37 years served as health officer for the village of Waterford and the surrounding townships.

He was a life member of the Racine County Medical Society and the State Medical Society, and was a member of the American Medical Association.

Survivors include his wife, a son, and three daughters.

Dr. Adolph J. Schloemer, 68, of Menomonee Falls died suddenly on June 12. He was born near West Bend on May 22, 1884.

A 1921 graduate of Marquette University School of Medicine, the doctor practiced for a number of years in the village of Jackson. Nineteen years ago he moved his practice to Menomonee Falls. Doctor Schloemer took advanced studies in internal medi-

cine and pediatrics at the University of Vienna, Austria, in 1923 and again in 1932.

He was a member of the Medical Society of Milwaukee County, the State Medical Society, and the American Medical Association.

Survivors include his wife, his son, Dr. H. F. Schloemer, and three grandchildren.

Dr. Carl O. Schaefer, 60, Racine physician for more than 33 years, died on June 20 at a local hospital after an illness of several weeks. He was born in Milwaukee on October 10, 1891.

A 1916 graduate of Marquette University School of Medicine, the doctor served his internship at Trinity Hospital in Milwaukee prior to establishing his practice in Racine. During World War I, he served as a staff physician with the Army Medical Corps in France.

Doctor Schaefer was a past president of the Wisconsin Chapter of the College of Chest Physicians and of the Racine County Medical Society. He was a member of the American College of Surgeons, the State Medical Society, and the American Medical Association.

He is survived by his wife and a daughter.

Dr. William F. Grotjan, 72, who had practiced in Milwaukee for 48 years prior to his retirement last September, died on June 28 at a local hospital following an illness of 10 months.

The doctor was born in Minneapolis on March 21, 1880. After receiving his medical degree from the old Marquette Medical College in 1904, he interned at Milwaukee County Hospital. He then established his practice in Milwaukee where he maintained an office until his retirement.

Doctor Grotjan had served on the staffs of Deaconess, St. Joseph's and Johnston Emergency Hospitals. He was an honorary member of the Milwaukee Academy of Medicine, as well as a member of the Medical Society of Milwaukee County, the State Medical Society, and the American Medical Association.

Survivors include his wife and two sons.

Dr. D. N. Walters, Fond du Lac physician, died on June 21 at a local hospital. He was 62 years old.

Born in Ironwood, Michigan, on July 6, 1889, he moved to Fond du Lac with his parents when a boy. He graduated from Marquette University School of Medicine in 1913 and received his license to practice in Wisconsin that same year. Doctor Walters served his internship at the Northern Pacific Hospital in Missoula, Montana, and then established his first practice in Campbellsport.

Two years later, the doctor returned to Fond du Lac where he was associated with the Fond du Lac Clinic for eight years prior to opening his own office in 1926.

Doctor Walters had served as secretary of the medical staff at St. Agnes Hospital and was appointed chief of staff there in 1951. He was a member of the American Academy of General Practice,

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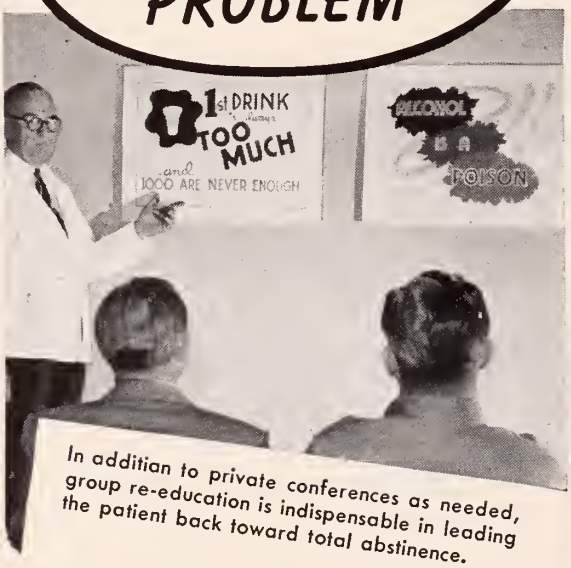

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Survivors include his wife, a daughter, and a son.

Dr. C. S. Williamson, 55, formerly of Green Bay, died on June 3 in Arroyo Grande, California. He was born on December 11, 1896 in Columbia, Missouri.

A 1920 graduate of the University of Pennsylvania School of Medicine, he served for two years as first assistant to Dr. Frank Mann of the Mayo Research Laboratory. He became a fellow in surgery in 1923 at Mayo Clinic and was appointed first assistant in surgery in 1925. In 1926 he received his master of science degree in surgery from the University of Minnesota.

He left the Mayo Clinic in 1926 to become head of the surgery department of the University of Arkansas School of Medicine, and in 1928 he moved to Green Bay where he, with Dr. E. M. Jordan and Dr. R. L. Troup, founded the Green Bay Clinic.

Doctor Williamson was a past president of the Brown–Kewaunee–Door County Medical Society and a fellow of the American College of Surgeons. He also held membership in the Milwaukee Society of Clinical Surgery, the Wisconsin Surgical Society, the Western Surgical Association, and the American Medical Association.

Surviving are his wife and a daughter.

Dr. Russell J. C. Strong, 83, a former Beloit physician, died on June 11 in Milwaukee where he had lived for several years.

He was born in Beloit on November 22, 1868, the son of Dr. H. P. Strong who served as president of the State Medical Society in 1871. The doctor graduated from Beloit College in 1896 and received his medical degree from the Wisconsin College of Physicians and Surgeons in 1900. Doctor Strong did postgraduate work at Rush Medical School, Johns Hopkins, and at the University of New York. He practiced in Beloit for a number of years, doing most of his work in internal medicine, before joining the staff of the state tuberculosis sanatorium at Wales.

Survivors include his two sons, Dr. R. G. Strong of Manitowoc and C. P. Strong, Atlanta, Georgia.

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AMERICAN MEDICAL ASSOCIATION news notes

AMA news written especially for use in state medical journals

AUGUST, 1952

AMA Offers Aid to Discharged Doctors

A new program has been set up by the American Medical Association to acquaint physicians newly-discharged from the armed forces with existing opportunities in private practice, industry, hospitals and medical schools throughout the country.

Inaugurated by the Council on National Emergency Medical Service, the plan will contact army, navy and air force physicians before they are discharged to find out if they have any post-service plans. If the doctor has not made any plans, he may indicate to the Council where he wants to locate and in what field of medicine he is interested. This information will be sent to state medical societies and to state medical advisory committees to the Selective Service System. Correspondence with individual physicians on these lists will be handled by either the state advisory committees or the medical societies.

AMA Conducts Survey on Research Projects

Questionnaires will be sent out this month by the AMA's Committee on Research to determine what medical research projects currently are in progress throughout the country. The survey has a three-fold purpose: To establish an up-to-date file of medical research projects; evaluate the premise that certain fields of medical research are suffering from lack of financial support, and consider the actual contribution of individual scientists in terms of free time and personal expenditure of funds. A random sample of 15,000 physicians from all parts of the United States and selected personnel from medical schools, public health services and pharmaceutical firms will be asked to participate in the survey.

Standards for Indigent Care

The Committee on Indigent Care of the AMA's Council on Medical Service has outlined the following criteria for developing indigent medical care plans.

The Committee believes that indigent medical care plans should provide all the services which normally are available locally to other citizens, and should make equal services available to all indigent persons —the blind, old age pensioners, dependent children. Also, the Committee feels that such a plan should provide for medical supervision and, wherever possible, offer a free choice of physician for both home and office care. The plan should use existing facilities, avoid duplication and provide for local administration by a single agency of the medical program for all groups concerned.

The Committee believes that medical care for the indigent is a local problem requiring the wholehearted cooperation and participation of local physicians. Such plans should be administered locally regardless of the source of funds.

AMA Studies Allied Scientific Fields

The American Medical Association has deferred action on the establishment of any new specialty boards involving the certification of persons who are not doctors of medicine until after the Council on Medical Education and Hospitals has completed its study of all allied scientific fields. This report will include studies of various professional non-physician groups whose work is closely related to the practice of medicine, such as clinical chemistry and clinical psychology.

New Heart Disease Transcriptions Available

A new series of radio transcriptions entitled "The Heart of America" will be released September 15 by the AMA's Bureau of Health Education. Dramatizing various aspects of the heart and its diseases, the 13 programs in the series are summarized by outstanding cardiologists and related experts.

Subjects include: research in heart disease; heart murmur; rheumatism and rheumatic heart disease; the congenital heart disease program; the heart and athletics; coronary disease; overweight and the heart; arterial disease; high blood pressure and the heart; surgery for heart valve and arterial diseases; the heart in relation to stresses and strains; rehabilitation; protecting the good heart from injury, and how to live with a damaged heart. The series was produced in cooperation with the American Heart Association.

Hospital Rating Office Opens

Director Edwin L. Crosby, M.D., former superintendent of Johns Hopkins Hospital, Baltimore, opened the new Joint Commission on Accreditation of Hospitals office September 1 at 660 Rush Street, Chicago. The Commission, with representatives from the American Hospital Association, the American College of Surgeons, the American College of Physicians, the Canadian Medical Association and the American Medical Association, will assume responsibility for the hospital standardization program formerly carried out by the American College of Surgeons. The Commission's program will get under way early this fall.

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THE JOURNAL BOOKSHELF

Members of the Society may obtain loan packets on any medical topic they wish to study.

All of the current medical journals received by the State Medical Society on an exchange basis, and the medical text books reviewed in *The Journal "Bookshelf,"* are given to the Medical Library Service and then become available to any physician in Wisconsin who indicates his desire to use them. All that is required is for the physician to advise the Medical Library Service that he wishes a loan packet on the specific subject he wishes to study. Packets, for example, may be obtained on: acute appendicitis, treatment of fractures of femur, medical or surgical treatment of ulcers, poisons in industry and many others.

Address as follows: Medical Library Service, Service Memorial Institute Building, North Charter Street, Madison, Wisconsin.

Spatial Vector Electrocardiography, Clinical Electrocardiographic Interpretation. By Robert P. Grant, M.D.; and E. Harvey Estes, Jr., M.D. Philadelphia, New York, Toronto, The Blakiston Company, 1951. Price $4.50.

This relatively small compact book of 145 pages is divided into two parts. The first part describes the spatial vector method of interpreting electrocardiograms, and the second part deals with the clinical application of vector analysis. The method as described by these authors consists of plotting mean vectors from the QRS complexes of the standard electrocardiogram. This is done in two known planes such as the frontal and sagittal, or frontal and coronal. From the characteristics so calculated the direction of the vector in space (three dimensions) can be determined. Not only the three limb leads but also the six precordial V-leads may be employed in the calculation. A similar mean spatial vector is determined from the T-waves. In addition to the spatial vectors, a spatial "loop" can be plotted from the QRS complexes. The frontal projection is obtained from the limb leads and the coronal projection from the precordial leads. By combining the two a spatial loop can be plotted in three dimensions. S–T–T loops can be derived similarly.

In Part II the authors describe various abnormalities of the QRS and T vectors, their relation to corresponding "patterns" in the standard electrocardiogram, and the specific types of cardiac pathology with which these changes are commonly associated. The authors point out that the spatial vector electrocardiogram is useful in making an unequivocal diagnosis of acute myocardial infarction, recognizing the "healed" infarct, determining the significance of the Q wave, and evaluating other electrocardiographic changes which constitute frequent sources of confusion. The authors repeatedly emphasize the viewpoint that the application of vector methods greatly simplifies electrocardiographic interpretation and they go to great lengths graphically to illustrate and explain the underlying principles on which the method is based. In spite of this the reviewer encountered considerable difficulty in obtaining a clear understanding of the method on the first or even the second reading and found it necessary to study the subject matter over and over before being able to grasp the idea which the authors intended to convey.

There is room for improvement in the organization of the material and the manner in which it is presented. All too frequently the authors introduce a concept only to abandon it prematurely with the promise to "discuss it in more detail later." This results in a disconnected presentation of an admittedly complex subject which, for the beginner, needs the utmost simplification possible. The material is there if one has the patience to dig it out, but in the opinion of this reviewer the poor organization of the material, the author's unfortunate "wordy" style of writing, and the lack of clarity throughout render this book difficult for the beginner to digest.—C. M. K.

An Experience in Health Education. Battle Creek, Michigan, the W. K. Kellogg Foundation, 1951.

"An Experience in Health Education" is an authoritative account of new technics in health education. The experiences, during a six year period, of the School-Community Health Project, promoted and financially assisted by the W. K. Kellogg Foundation, form the basis of the report.

The project is a direct result of the last World War when, in 1942, a scarcity of nurses in the hospitals of Battle Creek, Michigan, led to the training of school girls to serve as nurses aids. The success of this program and the awareness of the deplorable physical deficiencies and emotional maladjustments of our American youths, as revealed by the startling number of World War II military rejections, stimulated a movement for a more realistic approach to health education.

The pattern of procedure followed in establishing the projects in 24 states is given in detail. The roles played by all groups involved in setting up such a program are described.

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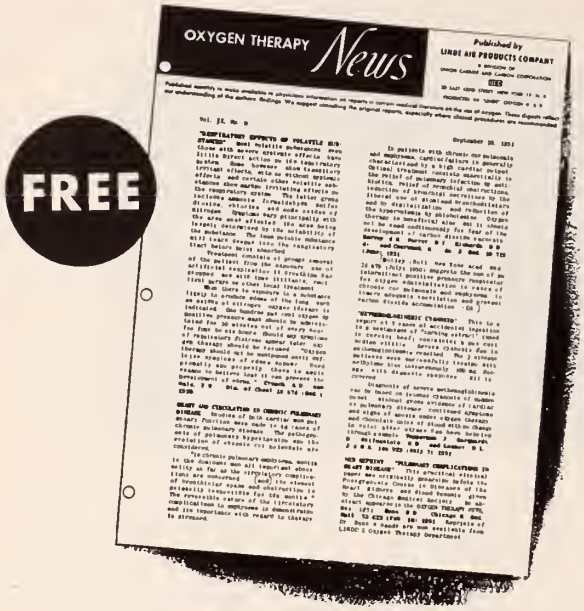

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tions such as the State Health Council, the State Health Coordinator, the local school administrations and the universities and colleges, which are directly responsible for the preparation of the teachers, who play the most important part in health teaching.

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Examples of constructive community projects are given. The hookworm eradication program of Greensboro, Florida, the establishment of excellent Well-Baby Clinics in southeastern Nebraska, and other experiences illustrate the effectiveness of active health teaching in our schools.—K. E. S.

Clinical Allergy; A Practical Guide to Diagnosis and Treatment. By Samuel J. Taub, M. D., F. A. C. P., professor of medicine and chairman of the department of allergic diseases, the Chicago Medical School; professor of medicine, Cook County Graduate School; attending physician, Cook County, Columbus, and Mt. Sinai Hospitals. Second edition. New York, Paul B. Hoeber, Inc., 1951. Price $4.50.

Dr. Samuel J. Taub states in the preface of the second edition of his new book "Clinical Allergy" that his intent is to provide the general physician with a clear, simple, and accurate guide to effective diagnostic and therapeutic measures which can be readily applied in practice; and further, that he has made every effort to avoid theory and controversy regarding technical details which he feels

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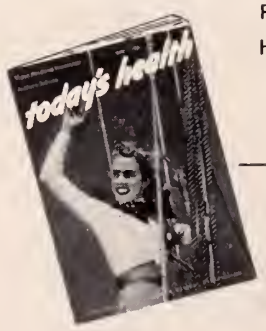

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would be of interest only to the specialist. He fulfills this purpose by providing simple, readable, text material in interesting fashion. The immunochemistry of allergy is dealt with in simple terms, and there is an equally well written chapter on "perennial hayfever." The appendix is replete with much useful information.

As a reference book to complicated allergic problems, it is not adequate but this was not the author's intent in the first place. There are several expressions with empirical and traditional assumptions concerning mechanisms of the production of the pathology of the allergic states. There are necessarily several rather dogmatic statements made throughout the text which do not reflect the controversial or newer opinions on several subjects, including mechanisms of the allergic state. There is no bibliography. These objections, however, do not conflict seriously with the author's attempt to provide an interestingly written and useful book for the physician who treats ordinary forms of allergy. As qualified by the limitations set in its preface, this book deserves a place in many libraries. —J. R. T.

The Battle for Mental Health. By James C. Maloney, M. D., New York, Philosophical Library, Inc., 1951.

This book is not a complete discussion of the subject matter of mental health. Its purpose is to point out one problem which the author believes is essential for improving the mental health of future generations. He deplores the present rigid methods of handling infants after birth in hospitals. He believes that these customs increase the already existent tension in the mothers, which is transmitted to the infants. His plea is for the greater use of the "Cornelian Corner" system of rooming-in after birth. By this method be believes the mother is made more secure with the child and will continue to handle the child, as he grows up, with a more permissive attitude.

Although Dr. Maloney quotes many statistics to prove the increase in this country of nervous and mental disease, as well as crime, his conviction that this trend would be changed by the "Cornelian Corner" can hardly be accepted as more than a part of the solution to the problem.—E. R. H.

Technical Methods for the Technician. By Anson Lee Brown, B.A., M.D., president of Anson L. Brown, Incorporated, successor to Dr. Brown's Clinical Laboratory and Dr. Brown's School for Technicians, Columbus, Ohio. Columbus, Ohio, Anson L. Brown, Inc., 1951. Price $10.00.

Superficial examination of this book reveals a number of interesting features. Detailed study, however, brings forth a variety of inaccuracies and shocking omissions. Just to mention a few of the many examples, allow me to say that no one could possibly conduct a satisfactory prothrombin test (Quick method) with the amount of explanation offered. The determinations for serum bilirubin are not up to date. Urobilinogen determinations on stool and urine specimens are not mentioned.

The training of student technicians is not an easy task. Many of us are violently opposed to a "cook book" method of teaching. Yes, we want a technician trained in modern methods, but, in addition, we want a technician who knows why she is doing the procedures recommended.

There are a number of textbooks and laboratory manuals on the market which are far superior to this preparation.—W.J.

The American Illustrated Medical Dictionary. By W. A. Newman Dorland, A.M., M.D., F.A.C.S., Lieutenant-Colonel, M.R.C., U.S. Army, Former Member of the Committee on Nomenclature and Classification of Diseases of the American Medical Association. Philadelphia and London, W. B. Saunders Company, 1951. 22nd Edition. $10.00.

It has long been an axiom to users of medical dictionaries that the best dictionary is "the one that gives what you are looking for." It is obviously impossible for any one dictionary to give an acceptable definition for everything from colocentesis to cerebral angiography, and the editor of a medical dictionary steers an uneasy course between too drastic an elision of words now obsolete but still to be encountered as survivals, and too liberal an inclusion of obsolete words that never entered the currency of active use.

The latest edition of any dictionary has very definite advantages, and the new Dorland is no exception. Celebrating the completion of 50 years of publication, it has been thoroughly revised and is larger than its competitors by several hundred pages and 50,000 words. It is no longer the old familiar "illustrated medical dictionary." Illustrations of anatomical structures, instruments, and various cells and organisms have been retained, but the little portraits are missing. (It can only be conjectured that the familiar sketches of Aesculapius and Hippocrates have been retained because they are so obviously not portraits.)

Tables of arteries, muscles, nerves, stains and tests, etc., accompany the definitions in the text, and there is only one appendix: "Modern Drugs and Dosages," by Austin Smith, M.D. Type and paper are excellent, but the flexible binding is likely to prove inadequate to the increased size and weight, if the volume is to be shelved upright. With this single reservation, the dictionary can be recommended as a highly satisfactory addition to any library or medical office.—H. C.

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* These stations also carry programs at 7:00 p.m. on Wednesdays on FM only.

PHYSICIANS' EXCHANGE

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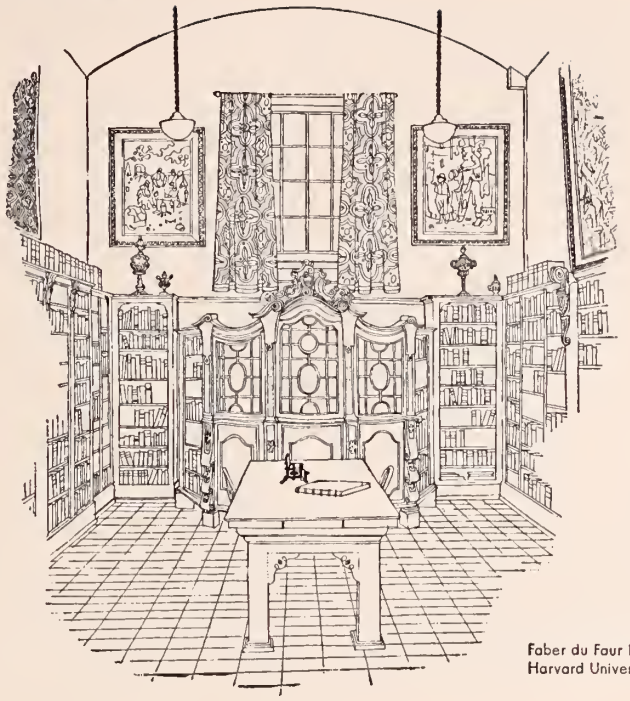

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COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Ashland-Bayfield-Iron	C. A. Grand 522 W. 2nd Ashland	J. E. Kreher 522 W. 2nd St. Ashland	
Barron-Washburn-Sawyer-Burnett	R. E. Lund Cumberland	Clive J. Strang Barron	Second Tuesday 7:30 p.m.
Brown-Kewaunee-Door	J. L. Ford 3030 S. Webster Green Bay	G. M. Shinners 409 E. Walnut Green Bay	Second Thursday*
Calumet	E. P. Larme New Holstein	L. W. Keller Brillion	
Chippewa	T. D. Foster Cornell	B. F. Rahn Cadott	Second Tuesday
Clark	K. F. Manz Neillsville	J. W. Koch Owen	
Columbia-Marquette-Adams	R. F. Inman Montello	E. G. Nafziger Oxford	Second Tuesday 7:00 p.m.
Crawford	O. E. Satter Prairie du Chien	H. L. Shapiro Prairie du Chien	
Dane	G. H. Ewell Jackson Clinic Madison	G. C. Hank 110 E. Main Madison	Second Tuesday
Dodge	C. L. Qualls Beaver Dam	R. E. Urbanek Beaver Dam	Last Thursday*
Douglas	C. T. Droege 1507 Tower Superior	R. T. Anderson 1507 Tower Superior	First Wednesday** Badger Room of the Hotel Superior
Eau Claire-Dunn-Pepin	W. G. Cameron 131 S. Barstow Eau Claire	H. E. Sorensen 314 E. Grand Eau Claire	Last Monday
Fond du Lac	R. W. Steube St. Agnes Hospital Fond du Lac	H. R. Sharpe, Jr. 92 E. Division Fond du Lac	Fourth Thursday*
Forest	O. S. Tenley Wabeno	D. V. Moffet Crandon	
Grant	N. G. Rasmussen Montfort	H. W. Carey Lancaster	Last Thursday, March, June, Sept. and Nov.
Green	D. D. Ruehlman Monroe	L. G. Kindschi Monroe Clinic Monroe	
Green Lake-Waushara	Roy Hong Wild Rose	R. S. Pelton Markesan	Last Thursday, every other month starting in Jan.

List of Officers and Scheduled Meetings of County Medical Societies—Continued

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Iowa	C. L. White Mineral Point	H. M. Walker Dodgeville	First Thursday following first Monday
Jefferson	E. A. Miller 133 Riverlawn Watertown	E. J. Netzow Lake Mills	Third Thursday*
Juneau	J. S. Hess Mauston	M. S. Tverberg Mauston	Second Tuesday Hess Clinic in Mauston
Kenosha	H. L. Schwartz 625 57th Kenosha	Helen A. Binnie 7609 25th Kenosha	First Thursday* Elks Club Kenosha
La Crosse	J. J. Satory 1707 Main La Crosse	D. M. Buchman 308 Newburg Bldg. La Crosse	Third Monday
Lafayette	D. J. Garland Shullsburg	N. A. McGreane Darlington	First Tuesday
Langlade	D. W. Dailey Elcho	F. H. Garbisch Antigo	Second Wednesday
Lincoln	L. J. Bayer Merrill	J. D. Millenbah Merrill	
Manitowoc	C. J. Radl Wood Block Manitowoc	W. C. Randolph 819 Hancock Manitowoc	Last Thursday
Marathon	D. M. Green Trust Bldg. Wausau	G. R. Hammes 529½ 3rd Wausau	
Marinette–Florence	J. M. Bell 1723½ Main Marinette	R. J. Rogers Oconto	Third Wednesday St. Joseph's Hospital
Milwaukee	N. J. Wegmann 2510 W. Capitol Milwaukee	W. T. Casper 2218 N. 3rd Mr. J. O. Kelley, Ex. Sec. 208 E. Wisconsin	Second Thursday
Monroe	C. E. Kozarek Tomah	J. S. Mubarak Tomah	Third Monday
Oconto	H. A. Aageson 1113 Main Oconto	G. R. Sandgren Suring	
Oneida–Vilas	G. R. Thuerer 1020 Kabel Rhinelander	Marvin Wright 1020 Kabel Rhinelander	Monthly
Outagamie	L. B. McBain 128 N. Durkee Appleton	W. A. Adrians 118 W. College Appleton	Third Thursday* Elks Club 6:30 p.m.
Pierce–St. Croix	E. F. Hill Spring Valley	P. H. Gutzler River Falls	Third Tuesday
Polk	W. A. Fischer Frederic	G. B. Noyes Centuria	Third Thursday 7 p.m.
Portage	M. G. Rice Stevens Point	H. A. Anderson Stevens Point	
Price–Taylor	J. L. Murphy Park Falls	J. J. Leahy Park Falls	Last Saturday, Feb., May, Aug., and Nov.
Racine	J. M. Albino 710 Main Racine	J. G. Jamieson 812 Main Racine	Third Thursday
Richland	J. I. Spear Richland Center	L. M. Pippin Richland Center	First Tuesday Richland Hospital
Rock	M. M. Baumgartner 508 W. Milwaukee Janesville	J. F. Pember 508 W. Milwaukee Janesville	Fourth Tuesday
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Washington–Ozaukee	P. B. Blanchard Cedarburg	K. F. Pelant Grafton	Fourth Thursday
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Waupaca	L. G. Patterson 122 S. Main Waupaca	R. E. Bolinske Clintonville	
Winnebago	W. E. Clark 19 Jefferson Oshkosh	B. S. Greenwood 19 Jefferson Oshkosh	First Thursday
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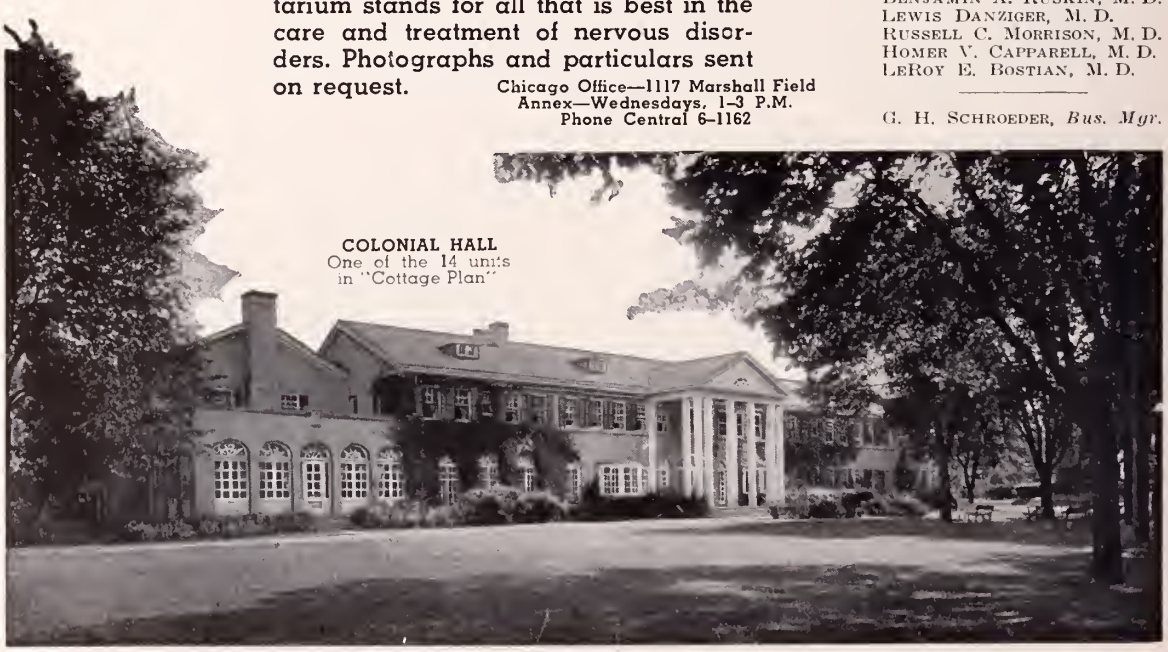

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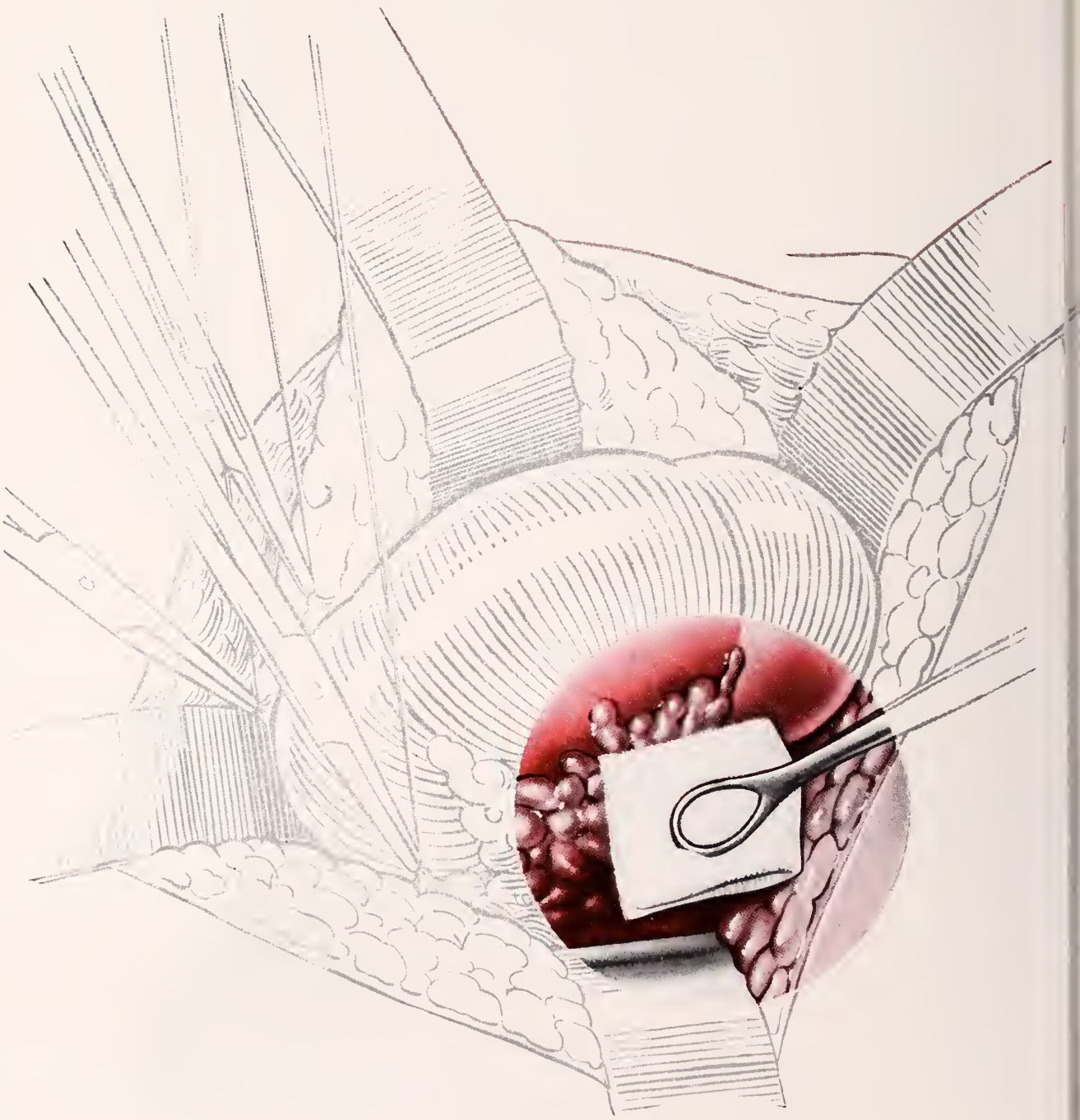

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*Davis, W. D., Jr.: A Critical Evaluation of Therapy in Cirrhosis of the Liver, South. M. J. *44*:577 (July) 1951.

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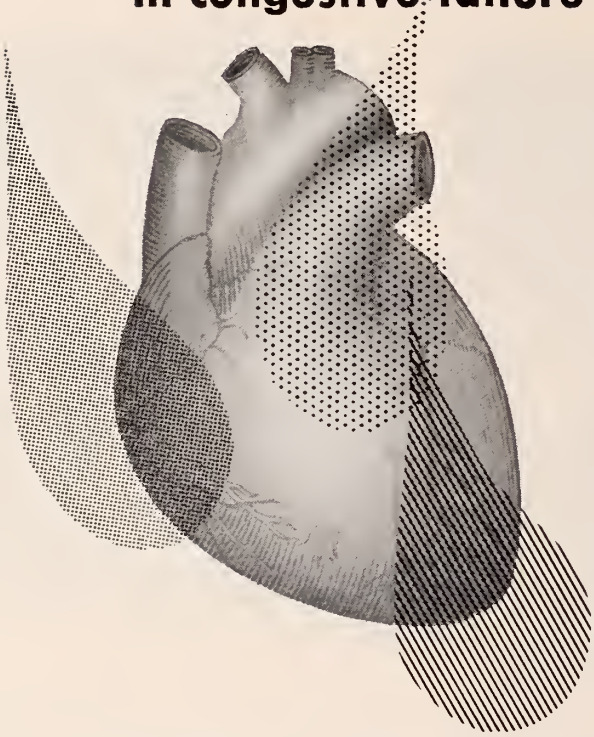

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« « « EDITORIALS » » »

Medical Ethics: The Gauze Curtain

Reprinted From MacLean's, Canada's National Magazine, and the Milwaukee Sentinel.

Ask the average person to describe his or her doctor and the portrait will be strongly touched with respect and even affection. Ask the same person to describe the Doctor as a species and you often get a different picture.

The small d doctor, the doctor most of us know and deal with as a living individual, isn't always the rumpled caricature of Santa Claus the movies make him out to be. But he isn't the remote, forbidding dignitary who comes so easily to mind when most of us begin to think of him in terms of the large D, as the symbol of a profession.

The small d doctor, the doctor most of us know personally, works harder than any human being has a right to work. The large D Doctor, the Doctor we know as a symbol, spends his afternoons on the golf course, his weekends at the lake and his winters in Florida or California. The doctor charges reasonable fees and sometimes forgets to send the bill; the Doctor charges as much as the traffic will stand and would appreciate payment no later than the first of the month. When a new treatment or a new drug turns up, the doctor tries to find out how good it is, in the hope that it may help his patients; the Doctor rejects it out of hand, for he is opposed to progress. The doctor remembers to tell small, silly jokes to small, silly children, so that they will be less afraid; the Doctor affects an inscrutable Olympian air, even when he is leering at the nurses. The doctor maintains an open heart and an open mind; the Doctor maintains a closed mind and a closed corporation.

One of these two sets of impressions must be very seriously wrong. Yet the two impressions do exist, side by side, often in the same minds. The Doctors themselves are becoming aware of it. They are beginning to see it is a threat—not yet very large, but still too large for ignoring—to the confidence and good will which must flow between the doctor and the patient if the doctor is to receive the satisfaction to which the practice of a great and noble art entitles him and if the patient is to receive the full benefits in better health. They are beginning to see it as a threat to scientific advancement in their field, for it is the patient who must, finally, provide the money for new laboratories and new research and often he must turn it over to the Doctor on trust, with neither of them able to say for certain what it will produce.

There is danger for all of us in this anomaly that the medical profession, as a profession, has come to

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seem so alien and distant from the public it serves and even from its own individual members.

Whose fault is it? The Doctor's, mainly.

In medicine, as in most other things, it is the unknown of which we are most suspicious. If the medical profession has incurred unjust suspicion, it has also tried too hard to make itself unknown. It has perpetrated the myth that a doctor who consents to satisfy the public's legitimate interest in himself and his work brands himself as rather low and self-seeking. This myth goes under the name of ethics. It is unethical for a doctor to get his name or picture into the papers, except in circumstances so difficult to define that many doctors with great achievements to their credit remain anonymous rather than risk the disgrace of becoming famous. It is unethical for a doctor to talk about a new operation, a new drug or a new theory of his own devising, at least until the skepticism of his fellow doctors has been exhausted—and along with it the excitement of the discovery. It is unethical for any doctor to talk about the work of any other doctor, except in terms so ridden with platitudes and hedged against any hint of criticism that what he says loses much of its meaning.

The instinct underlying all this is decent, good and modest. No one—not even an editor who hates to see good stories go to waste or remain only partly told—wants to see our doctors hiring press agents and distorting their character and their work for the sake of attention. But where its work and its workers merit attention, we believe the medical profession harms itself by hiding them behind a gauze curtain labeled ethics.

The Democratic and Republican Party Platforms Relating to Compulsory Health Insurance

The plank adopted by the Republican Convention regarding health insurance was so definite and unequivocal that it is given in its entirety below:

"We recognize that the health of our people as well as their proper medical care cannot be maintained if subject to a federal bureaucratic dictation. There should be a just division of responsibility between government, the physician, the voluntary hospital, and voluntary health insurance. *We are opposed to federal compulsory health insurance with its crushing cost, wasteful inefficiency, bureaucratic dead weight, and debased standards of medical care.* We shall support those health activities by government which stimulate the development of adequate hospital services without federal interference in local administration. We favor support of scientific research. We pledge our continuous encouragement of improved methods of assuring health protection."

The Democratic Party Platform relating to health insurance was considerably watered down from the previous stand taken by President Truman and is also more moderate than the party's previous position. However, it is still somewhat anemic. The pertinent portion of its platform comes under "*Cost of Medical Care*" in which it states: "We also advocate a resolute attack on the heavy financial hazard of serious illness. We recognize that the costs of modern medical care have grown to be prohibitive for many millions of people. We commend President Truman for establishing the non-partisan commission on the health needs of the nation to seek an acceptable solution of this urgent problem."

This plank, however, does pay indirect tribute to the effectiveness of the doctor's crusade against socialized medicine in that it seeks to remove the issue from consideration during the forthcoming presidential and congressional election campaigns.

This writer is against telling anyone how to vote in the coming November elections, but we feel the issues have adequately been brought out by our perusal of each party's platform and feel that every doctor in this state will be remiss if he does not register his preference in the coming election.

Socialized Medicine Through the Back Door

The editorial appearing in the *A.M.A. Journal* of August 23, 1952, entitled "Socialized Medicine, the ILO Way" bears repeating and justifies the sober thought of all of our Society.

Apparently the inroads of socialism into medicine have at least been temporarily stopped on the national level, but the new approach is an international one. The same left wing forces which we have been fighting nationally have been finding it much easier to work through the United Nations and the International Labor Organization. Through the wholesale approval of treaties, conventions, and executive agreements, our international representatives have placed not only American medicine but our national sovereignty and our constitution in jeopardy.

The crux of this discussion, as set out in the A.M.A. editorial, is a recent covenant entitled "Minimum Standards of Social Security," approved by the International Labor Organization in Geneva in June 1952. While the medical benefits in the covenant are carefully distributed through the document, considered together, they constitute socialized medicine.

This is a much more subtle approach than has previously been tried. Nevertheless, it is just as effective, and, unless we acquaint our representatives in Congress with our feelings on the matter, we may lose the battle against socialism by treaty even though we seem to have won that against socialism made in America.

Comments from the Wisconsin Press

Medical Care Costs

"One of the frequent gripes we hear is that of the high cost of being sick. That it can be extremely expensive, no one can deny. But expensive though it may be, there is evidence to show that medical care costs have not risen nearly as sharply as most other items in the consumers' budget.

"The American Medical Association's Bureau of Medical Economic Research recently made a study of the rise in medical care costs in relation to the rapid climb in the cost of living which this nation has experienced.

"It found that in 1951 the price index on all items in the consumers' budget rose almost twice as many points as the cost of medical care.

"Although medical care costs haven't kept pace with the general cost of living, we doubt whether anybody need feel sorry for the medical profession. The doctors seem to be doing all right by themselves."—WAUSAU DAILY RECORD-HERALD, August 11, 1952.

* * *

The Doctors and the Press

"The Wisconsin State Medical Society has just issued a bulletin to its members and to newspaper editors on a proposed relationship between the medical profession and the press.

"This statement of suggested relationship between professional men and the press did not just develop out of thin air. It came about through a series of six district medical meetings called by the Wisconsin State Medical Society to which representatives of the press and radio were invited. It so happened that the first of these meetings was held in Sheboygan, and The Sheboygan Press and Station WHBL were happy to participate in suggestions offered and in the subsequent discussion.

"A good relationship between the medical profession and the press is always healthy for the public interest. We congratulate Dr. A. H. Heidner, president of the state society, and others responsible for originating and calling the meetings which resulted in this fine statement of policy."—THE SHEBOYGAN PRESS, August 2, 1952.

* * *

Compulsory Health Insurance Is Sick!

"These planks (of the Republican and Democratic Parties)—the one very positive, the other something of a compromise—unquestionably reflect the fact that the policy-makers in both parties have come to the conclusion that the American people want no part of either socialized medicine or politically-dominated medicine.

"This doesn't mean that the public at large or Congress thinks that we have no health problems, and that nothing more needs to be done. Everybody concerned—including the doctors—recognizes these problems and is vitally interested in their ultimate solution. But the great majority want them to be solved without compulsory political tax measures of the type which have ominously reduced the standards of medical care in other nations. Very great progress has been made in a short period of time to better serve our health needs. Far greater progress will come in the future on a voluntary basis."—BURLINGTON FREE PRESS, August 12, 1952.

* * *

Interpreting the Public

"We will start by asking if the doctors realize how much their patients resent the cavalier way in which they often waste other people's time. Naturally, emergencies will frequently disrupt the appointment schedule. But we wonder if some do not book patients at impossibly frequent intervals, and then keep them waiting for hours, merely to be sure that they themselves never have to waste a minute.

"Any comment, doctor?"—CHICAGO DAILY NEWS, reprinted by THE MILWAUKEE JOURNAL, August 9, 1952.

* * *

85,991,000 Vote "No!"

"A report by the Health Insurance Council reveals that business-managed insurance companies are expanding their coverage so swiftly there is a good chance that they will out-race compulsory government health insurance and federal medicine.

"More people were protected through involuntary plans against sickness and accidents in 1951 than ever before in history, according to the Health Insurance Council's report.

"After allowing for duplication of coverage, there were 85,991,000 Americans with protection against hospital expense when 1951 ended, an increase of 12 per cent over the number of persons covered a year earlier.

"It is good to see these figures, and it is good to know that each year more citizens are taking steps—freely and voluntarily and with their own money—to protect themselves from economic hardship that illness and accident bring. The socializers, faced with these figures, can not successfully argue that the government must go into the insurance business because private industry isn't doing the job."—WISCONSIN STATE JOURNAL, July 9, 1952.

Cancer of the Stomach 33 Years After Gastroenterostomy For Bleeding Duodenal Ulcer*

By F. G. H. MALONEY, M. D. and O. ARTHUR STIENNON, M. D.
Madison

CANCER of the stomach is a rare complication following surgery for duodenal ulcer. It is also a rare complication of duodenal ulcer without surgery, an opinion held by many well qualified gastroenterologists and surgeons.

Eusterman and Balfour[1] state, "The presence of duodenal ulcer is in a certain sense an insurance against gastric carcinoma." Also "A person who has active duodenal ulcer and adequate gastric acidity is less subject to gastric cancer than is the normal person."

Bockus[2] writes, "I have found that duodenal ulcer patients with marked gastric hyperchlorhydria and hypersecretion rarely die of gastric cancer. I have been in the habit of attempting to dispel a cancer phobia in patients with duodenal ulcer by stating that, in my experience, patients with this disease are much less likely to have cancer of the stomach develop than those who have no stomach disease whatever."

At a meeting of prominent Scandinavian surgeons, Olaf Romcke,[3] head of the medical department of Dramman Hospital in Norway, asked if any of them had ever seen a case of cancer of the stomach in a patient who had previously suffered from duodenal ulcer. None of the surgeons recalled having seen such a case. The same question was asked pathologists, but none could give a definite answer. Romcke ponders the question as to why patients with duodenal ulcer are to a certain extent immune against cancer of the stomach. He believes it bears some relation to gastritis and also that the marked hyperacidity associated with duodenal ulcer may play a part in preventing cancer. To support this theory, he calls attention to an article published by Comfort, Kelsey and Berkson[4] of the Mayo Clinic in 1948. While investigating a series of cancer of the stomach, these workers found that a group of 277 patients had known subnormal gastric acidity for at least two years or more before the onset of their carcinoma of the stomach.

Romcke classifies people into the following four groups as to their possibility of developing carcinoma of the stomach:

Group 1.—Those with pernicious anemia. This group is predisposed to cancer of the stomach.

Group 2.—Those with gastric ulcer. This group is also predisposed to cancer of the stomach.

Group 3.—Normal individuals.

Group 4.—Those who have a duodenal ulcer. This group is to a certain extent immune to cancer of the stomach.

In 1930 Balfour[5] reviewed 500 consecutive cases of duodenal ulcer in which gastroenterostomy had been performed during the years 1918 to 1919. There was no instance of carcinoma developing subsequent to the gastroenterostomy.

In 1933 Wilbur and Rivers[6] searched the voluminous records of the Mayo Clinic and found only 33 instances in which proved cancer of the stomach was found coincidentally with duodenal ulcer. Four of these patients had previously undergone gastroenterostomy for duodenal ulcer, and one had previously undergone excision of duodenal ulcer and pyloroplasty.

In 1938 Portis and Jaffe[7] of Cook County Hospital, Chicago, made an exhaustive analysis of peptic ulcers found in the stomach and duodenum in 9,171 consecutive postmortem examinations. They found a total of 240 gastric ulcers and 215 duodenal ulcers. There was a combination of gastric and duodenal ulcer in only 19 cases, but in *no* patient did they report a gastric cancer associated with a duodenal ulcer.

In 1940 Christiansen[8] reviewed the records of 500 patients in whom he had found organic lesions of the digestive tract by gastroscopic examination. Among these were 70 cases of roentgenologically verified duodenal ulcer. In 21 of these cases the mucous membrane of the stomach was normal, but in 49 of the 70 duodenal ulcer cases there were changes in the gastric mucosa varying from chronic superficial and chronic hypertrophic gastritis to solitary erosion and hemorrhage. In no case did he report finding a cancer of the stomach associated with the duodenal ulcer.

In 1947 Fischer, Clagett, and MacDonald[9] reported the incidence of combined duodenal ulcer and gastric carcinoma to be 1 in 938 or 0.1 per cent. This information was gleaned from the case history files of the Mayo Clinic covering a period of approximately 34 years up to January 1945. There were approximately 45,000 cases of duodenal ulcer, among which were 48 cases of concomitant duodenal ulcer and carcinoma of the stomach. Four of these latter cases had had previous surgery for the duodenal ulcer. In their comments on the low percentage of combined duodenal ulcer and cancer of the stomach, the authors thought that the hyperchlorhydria or even the bland diet in the medical treatment of duodenal ulcer might afford protection against gastric cancer for the patient having a duodenal ulcer.

*From the Department of Surgery, Quisling Clinic. Presented before the Sept. 22, 1951 meeting of the Wisconsin Surgical Society at Milwaukee.

However, the authors made no definite conclusion as to why carcinoma of the stomach rarely develops in patients who have duodenal ulcer.

Approaching the subject from another angle, Gray and Lofgren[10] reviewed the records of the Mayo Clinic for the 10 year period prior to Jan. 1, 1948. They found 41 patients in whom it was necessary to take down a gastroenterostomy which had been previously made for duodenal ulcer. In 11 of these 41 cases carcinoma of the stomach had developed as a complication of the duodenal ulcer following the gastroenterostomy. This series of 11 patients in whom carcinoma of the stomach developed some time after gastroenterostomy for duodenal ulcer is the largest single series reported in the literature to date.

Although none of the papers reviewed made a definite statement that hyperacidity was the factor that prevented cancer of the stomach from developing in a patient with a duodenal ulcer, the possibility was considered by all.

A comprehensive review of the world literature by Orringer[11] in 1950 disclosed only 27 authentic cases of cancer of the stomach complicating gastroenterostomy, or other surgery, for duodenal ulcer. To these 27 cases, he added 5 of his own, making a grand total of only 32 cases up to 1950.

Report of a Case

The case I wish to report is one in which carcinoma of the stomach developed 33 years after gastroenterostomy for bleeding duodenal ulcer.

The patient was a 60 year old (in 1950) white female, whose history of gastrointestinal trouble dated back to 1917, when a diagnosis of duodenal ulcer was made. The same year (1917) she had a severe hemorrhage, and a posterior gastroenterostomy was done at a Chicago hospital. Following that, she had three episodes of hemorrhage in 1922, 1927, and 1932. Since the operation the patient had eaten small amounts of food four to five times daily, because of a feeling of fullness and a tendency to "fill up easily." After an attack of cholecystitis in 1945, she had an aching pain under the right costal margin which radiated around to the back. The patient had an intolerance to heavy and fried foods and had been living on a bland diet. There had been occasional nausea and vomiting up to one and a half years ago. She had a normal bowel movement daily. There was no weight loss or melena. For two to three months prior to admission the patient had a tired and "all in" feeling.

In 1917 following the gastroenterostomy, a lung abscess developed that required three or four months to clear. In 1942 she had a subtotal hysterectomy for fibromyomata of the uterus.

Examination revealed a well developed, well nourished female in no distress. The abdomen bore the scars of her previous operations. There was slight tenderness in the lateral portion of the right upper quadrant and right flank. No other tenderness or masses were felt.

Fig. 1.—X-ray showing the large filling defect in the middle third of the stomach.

Routine laboratory studies were normal except for a moderate degree of anemia. A cholecystogram showed a non-functioning gallbladder, and colon x-ray was negative. X-ray of the stomach was reported by one of us (O.A.S.) as follows: As barium was ingested, the esophagus was normal in appearance. As barium entered the stomach, it immediately made its way through the efferent loop of the gastrojejunostomy. The efferent loop was then closed by manual pressure and barium could then be expressed into the duodenum in the normal fashion. There was a slight duodenal deformity, but the calibre of the bulb was good and there was no ulcer crater. The gastrojejunostomy site was located posteriorly. There was a large filling defect in the middle third of the stomach near the stoma of the gastrojejunostomy. This was constant and was associated with rigidity and a scalloped appearance of the greater curvature distal to it. A second large filling defect with concentric circular mucosal folds within it proved to be the stoma as seen *en face*.

The scalloped appearance of the greater curvature is characteristic of the so-called "*état mammelonné*," a polypoid stage of hyperplastic gastritis of Konjetzny.[13] It seems probable that gastritis developed following the surgical procedure and this in turn developed into a malignant neoplasm.

Impression:—(1) Malignant gastric neoplasm involving the middle one-third of the stomach with polypoid hyperplastic gastritis or polypoid neoplasm involving the major portion of the antrum; (2) old duodenal ulcer deformity; and (3) postoperative posterior gastrojejunostomy without evidence of

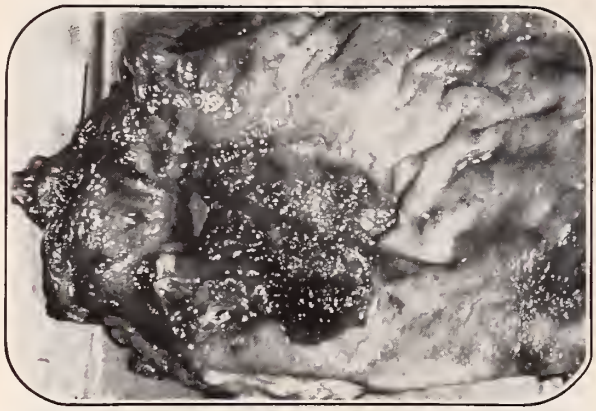

Fig. 2.—The stomach specimen showing the carcinoma surrounding over one-half of the old gastroenterostomy stoma and the scalloped margins of the greater curvature.

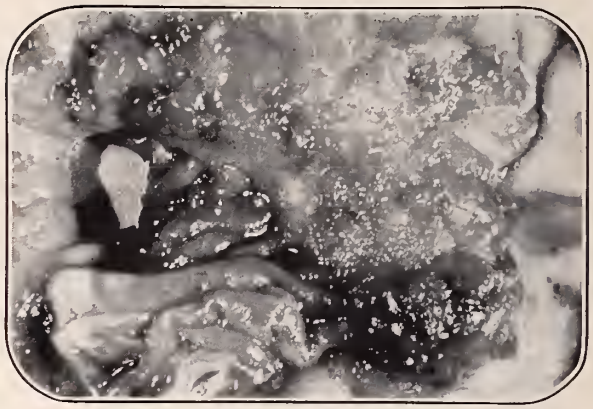

Fig. 3.—Enlarged view of figure 2.

obstruction or recurrent ulceration at the anastomotic site.

The diagnosis was made from the gastric x-ray examination and, after suitable preoperative preparation, the patient was explored by one of us (F.G.H.M.) on Oct. 25, 1950. A posterior short loop gastroenterostomy was present. A hard irregular mass two inches in diameter was palpable on the posterior wall involving the greater curvature of the stomach and extending up to the site of the gastroenterostomy stoma. No metastases were palpated in the liver or regional lymph glands. An anterior polya type of gastric repair was done after removing the lower two-thirds of the stomach with all the attached mesentaries and omentum. The patient made a good postoperative recovery and left the hospital after 18 days, eating well and in excellent condition.

Discussion

From the roentgen point of view the scalloped margins of the greater curvature in this case are of particular interest. They are considered characteristic of a rarely encountered form of gastritis for which European authors reserve the term *"état mammelonné."* Grossly these are seen as granular or "wart-like" elevations of the gastric mucosa. Histologically these have an adenoma-like character.[12] The latter finding has been offered in support of Konjetzny's[13] contention that gradual transitional forms occur between hyperplastic gastritis and frankly adenomatous growths. The gastric polyposis of the type frequently associated with pernicious anemia may be regarded as a later stage in this transition. Rigler[14] has recently called attention to the high incidence of gastric carcinoma arising in such cases. In the present case it seems reasonable to postulate a malignant transformation of one or more of the adenomatous areas. In view of the large number of gastrojejunostomies which were formerly done for the relief of peptic ulcer and the high incidence of postoperative gastritis following such operations, it is difficult to see why this sequence of events does not occur more frequently. The solution to this may lie in the difficulties of radiologic diagnosis in the surgically altered stomach, the prolonged follow-up period necessary to detect such malignant transformation, and the probability of the patient dying of other causes in the interim. In addition, the mere scarcity of reports of carcinoma in the postoperative stomach can hardly be recognized as evidence of a scarcity of diseases.

Summary

1. A case of carcinoma of the stomach developing 33 years after gastroenterostomy for bleeding duodenal ulcer is presented.

2. Gastric carcinoma is rarely found in a patient who has a duodenal ulcer.

3. It has been suggested that hyperacidity accompanying duodenal ulcer is one of the reasons that carcinoma of the stomach very rarely occurs in these patients.

4. The features of this case tending to support the possibility of a malignant gastric neoplasm developing from an inflammatory condition have been discussed.

5. Factors which might account for the low reported incidence of carcinoma in the surgically altered stomach are reviewed.

2 West Gorham Street

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Antibiotic Therapy*

By GEORGE C. OWEN, M. D.
Milwaukee

THIS review of antibiotic therapy will be limited to the discussion of three features which have been prominent during the current year. First, the prophylactic use of some of these agents, second, the problem of bacterial resistance, and third, combined therapy. The newer agents, or those not in common use such as neomycin, polymyxin, viomycin, and mycomycin, will not be discussed.

Prophylaxis

The lessons to be derived from the prophylactic use of sulfonamides have been reviewed during the year. We were reminded that the short term, universal application of these agents against the highly susceptible Menigococcus has dramatically controlled epidemics of this infection and virtually abolished carrier states among military personnel so treated. When this measure was introduced against the less susceptible gonococcus, sulfonamide resistant strains of this organism rapidly appeared. Moreover, when long term, universal prophylaxis of respiratory infections, particularly streptococcal infections, was attempted at some military posts, epidemics of severe streptococcal infections due to sulfonamide resistant strains of Streptococcus ultimately appeared. Fortunately penicillin became available at that time or disastrous results might have ensued.

Penicillin proved to be far more effective than the sulfonamides against group A hemolytic streptococci and has therefore been used to prevent infection with these organisms in individuals who have had rheumatic fever. Thus far penicillin resistant strains of these bacteria have not been reported. Recent evidence suggests that early treatment of streptococcal sore throats may prevent the occurrence of rheumatic fever or at least affect its course favorably. Procaine penicillin in doses of 300,000 units on diagnosis, and again at 48 hours, and 600,000 units at 96 hours, eradicates the Streptococcus from the throat in these patients and reduces antibody production. In patients who previously have had rheumatic fever, 15 to 25 thousand units of sodium penicillin should be used every three hours for 8 to 10 days. This regimen most effectively inhibits antibody formation and is therefore highly desirable in groups susceptible to the recrudescence of rheumatic fever.

Should these results be confirmed, it is plainly our obligation to undertake this means of preventing rheumatic fever. The authors point out that bacteriologic diagnosis is not essential to the establishment of the streptococcal origin of these sore throats, the situation often being recognized clinically by the abrupt onset, the rather high fever, the appearance of enlarged tender lymph nodes in the neck, and the common presence of exudate on the pharynx.

Not only has penicillin been used prophylactically against specific infections of the hemolytic Streptococcus and the gonococcus but also against Streptococcus viridans infection after tooth extraction. Here its effectiveness awaits further study. Despite the absence of conclusive evidence that this prophylactic measure will reduce the incidence of subacute bacterial endocarditis, its continued use seems eminently wise.

All of us are familiar with the more general application of penicillin in those enfeebled by any cause in surgical or obstetric practice, in comatose patients, in mild, self-limited, non-specific respiratory infections, or in the patient with congestive heart failure. The list can be extended indefinitely. Some of these uses are justified, some are questionable. That such universal application of penicillin is not without dangerous implications is borne out by recent investigations.

Bacterial Resistance

Perhaps the most significant factor in failure of antibiotic therapy is the development of organisms resistant to the agent used. With the wide-spread use of penicillin there have appeared from all over the western world reports of the emergence of penicillin resistant strains of hemolytic staphylococci, and an increase in staphylococcal infections generally. Evidence that this increase is related to the wide use of the antibiotic is suggested by the increase in the percentage of naturally occurring penicillin resistant strains from 12 per cent in 1942, before the days of penicillin therapy, to 50 to 68 per cent in recent years in various clinics in this country and abroad. Moreover, resistant strains have been recovered from patients who have never received penicillin, but who have been apparently infected by otherwise healthy carriers among hospital personnel and patients of whom large numbers have been found to harbor resistant strains of staphylococci in the nasopharynx.

Despite early reports that bacterial resistance seldom develops to terramycin and aureomycin, there is disillusioning evidence that strains of staphylococci resistant to both these agents are appearing, especially to terramycin. Resistance appears to be permanent and to be related in part to the production of penicillinase by the organism. There is no loss of virulence with the development of resistance,

*Presented before the One Hundred and Tenth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1951.

as attested by the severity of the infections occurring with these organisms. Staphylococcic scarlet fever has been described in patients being treated for other infections. Recently, severe dysentery due to coagulase positive hemolytic Staphylococcus aureus has occurred among patients being treated with aureomycin and terramycin.

During the investigation of the effect of large doses of terramycin upon tuberculosis, using 5 to 7 Gm. a day, we had an opportunity to observe one patient in a small group who developed a severe infection of a pre-existing pleurocutaneous fistula with a Staphylococcus resistant to both terramycin and penicillin, the latter of which he had never received. Fortunately, the organism in this instance remained sensitive to aureomycin and a good result was obtained with this agent. When this is not the case, the treatment of these infections becomes a major problem.

Combined therapy with penicillin and streptomycin has been used successfully. Chloromycetin should be considered, although sensitivity is lost to chloromycetin at times when it is lost to terramycin, as has been pointed out by several workers. Moreover, this agent may have toxicity for the hematopoietic system. Bacitracin or neomycin can be considered when the severity of the infection outweighs the dangers of the possible toxic effects of these two drugs.

Apparently, massive doses of penicillin alone usually accomplish nothing in these infections and may actually do harm. In this connection it should be mentioned that some evidence has been brought forward in the laboratory which suggests that, under appropriate conditions, penicillin may actually stimulate the growth of organisms which are only moderately sensitive or quite resistant to it. If this is true in human infections, it may account for some of the phenomena observed clinically and add caution to the use of this agent.

Combined Therapy

The simultaneous administration of 2 or more antimicrobial agents in the treatment of infections has seemed particularly attractive in the attack on organisms only partially responsive to single agents. The rather poor correlation between the response of the organisms in the test tube and in human infections has been used to justify indiscriminate combinations of antibiotic agents. However, certain combinations have proved to be effective, especially those involving streptomycin. Here there is the very distinctive problem of the prompt emergence of resistance of many organisms otherwise susceptible to this drug. Indeed, the early promise of streptomycin was threatened by the frequent and rapid appearance of resistance with disappointing clinical results. The effective combination of streptomycin, first with sulfadiazine and later with aureomycin, in the treatment of brucellosis has withstood the test of repeated clinical trial. Oral administration of streptomycin and various sulfonamides is extensively practiced in preparation for abdominal surgery. The use of streptomycin alone in the treatment of pulmonary tuberculosis was attended by the emergence of resistant strains of tubercle bacilli in about 70 to 80 per cent of patients. Further treatment with streptomycin in these instances usually resulted in failure of the disease to improve. The use of para-aminosalicylic acid, in doses up to 12 to 14 Gm. daily, in combination with streptomycin has, in patients not previously made resistant, reduced the incidence of resistance to only 10 per cent. This has permitted the highly desirable prolonged therapy of this chronic disease with increasingly beneficial results in appropriate cases. It is now imperative that streptomycin be used only in combination with PAS in the treatment of tuberculosis. Its use alone is seldom justified.

Another use of streptomycin in combination is that with penicillin in the treatment of enterococcus infections, notably subacute bacterial endocarditis. The Lancefield group D streptococci, of which Streptococcus fecalis is an example, usually show a moderate to high degree of resistance to both penicillin and streptomycin. Efforts to treat the 5 to 10 per cent of cases of subacute bacterial endocarditis due to these organisms with either agent alone has usually met with failure. It is too early to assess the value of aureomycin, terramycin, and chloramphenacol in these infections, but again failures have already been reported when individual agents have been used. Greater success has attended the combined use of streptomycin and penicillin in the small series of cases reported. The doses are large—500,000 units of crystalline penicillin intramuscularly every two hours, and 0.5 Gm. of streptomycin or dihydrostreptomycin intramuscularly four times daily. This regimen is continued for a period of 28 to 42 days when this is possible. It is indicated that *in vitro* studies suggest an additive effect of the two agents against the enterococcus. These are a few examples of successful combined therapy, illustrating first the delayed emergence of resistance to streptomycin, and second, the possible additive effect of two unrelated antibiotic agents.

The advent of aureomycin, terramycin, and chloramphenacol, with their broad therapeutic spectra, adds to the temptation to try new combinations in the treatment of stubborn infections. However, all of these agents are merely bacteriostatic. When used in combination with penicillin, there is good experimental evidence that they interfere with its bactericidal action, presumably because pencillin is most effective against rapidly multiplying organisms. If this experience in the laboratory can be translated to the clinic, such combinations may in fact be of little value in the treatment of human infections. Obviously, some discretion must be used in the exhibition of combinations of these powerful antimicrobial drugs. Thus far, the most successful combinations have been those well supported by bacteriologic and animal experimentation.

In summary, two points seem to emerge from this discussion. Widespread and indiscriminate use of the antibiotics may prove harmful to the individual patient and ultimately to those around him. Second, it seems apparent, that as the range of effective antimicrobial treatment widens, the need for constant cooperation between the bacteriologist and the clinician increases.

425 East Wisconsin Avenue.

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SCHEDULE OF PROGRAMS OF THE "MARCH OF MEDICINE"

On April 1, 1952, the March of Medicine began its seventh consecutive year of radio broadcasting. The programs, which are tape recorded, feature Dr. R. C. Parkin discussing various health problems with a lay person who is called "Your Medical Reporter." At present 32 stations in Wisconsin, one in Michigan, and one in Minnesota are cooperating in presenting this program as a public service feature. The most recent schedule is as follows:

Station	*City*	*Time*	
WHBY	Appleton	Saturday	8:30 a.m.
*WHKW	Chilton	Saturday	10:30 a.m.
*WHWC	Colfax	Saturday	10:30 a.m.
*WHAD	Delafield	Saturday	10:30 a.m.
WEAU	Eau Claire	Saturday	1:30 p.m.
KFIZ	Fond du Lac	Saturday	8:30 a.m.
WBAY	Green Bay	Saturday	5:45 p.m.
*WHLA	Holmen	Saturday	10:30 a.m.
WJMS	Ironwood, Michigan	Saturday	8:15 a.m.
WCLO	Janesville	Saturday	6:30 p.m.
WLIP	Kenosha	Saturday	11:15 a.m.
WKBH	La Crosse	Saturday	11:00 a.m.
WLDY	Ladysmith	Saturday	11:00 a.m.
*WHA	Madison	Saturday	10:30 a.m.
WIBA	Madison	Saturday	9:00 a.m.
WOMT	Manitowoc	Saturday	8:30 a.m.
WMAM	Marinette	Saturday	11:15 a.m.
WDLB	Marshfield	Saturday	10:45 a.m.
WIGM	Medford	Saturday	11:30 a.m.
WEMP	Milwaukee	Sunday	8:30 a.m.
WEKZ	Monroe	Friday	2:00 p.m.
WNAM	Neenah	Wednesday	8:30 a.m.
WOSH	Oshkosh	Saturday	11:00 a.m.
WIBU	Poynette	Thursday	2:30 p.m.
KAAA	Red Wing, Minnesota	Monday	9:15 a.m.
WOBT	Rhinelander	Saturday	9:15 a.m.
*WHRM	Rib Mountain	Saturday	10:30 a.m.
WJMC	Rice Lake	Saturday	10:00 a.m.
WRCO	Richland Center	Wednesday	3:45 p.m.
WHBL	Sheboygan	Sunday	1:00 p.m.
*WLBL	Stevens Point	Saturday	10:30 a.m.
WDOR	Sturgeon Bay	Thursday	9:15 a.m.
WDSM	Superior	Sunday	10:00 a.m.
WSAU	Wausau	Monday	4:15 p.m.

* These stations also carry programs at 7:00 p.m. on Wednesdays on FM only.

Congenital Dislocation of the Hip—New Concepts in Early Diagnosis and Treatment in Infancy*

By BRUCE J. BREWER, M. D.
Milwaukee

CONGENITAL dislocation of the hip has been a major catastrophe because the diagnosis is made late, usually when the child walks with a limp. It is a catastrophe because at that time changes in the hip joint have occurred that may be irreversible and one can seldom expect an "excellent" result.

The "new" concept in early diagnosis and treatment in infancy is not new in the literature, but these thoughts should be renewed in our minds so that earlier diagnosis can be made and treatment instituted before these irreversible changes in the hip joint occur.

Congenital dislocation of the hip with its manifestations of shortening of the thigh, limitation of motion of the hip, pain, and "duck waddle" gait are easily recognized at a late period. Congenital dislocation of the hip was, at some previous period, a potential dislocation, and it is my wish to present the clinical and radiographic signs of that period.

Figure 1.

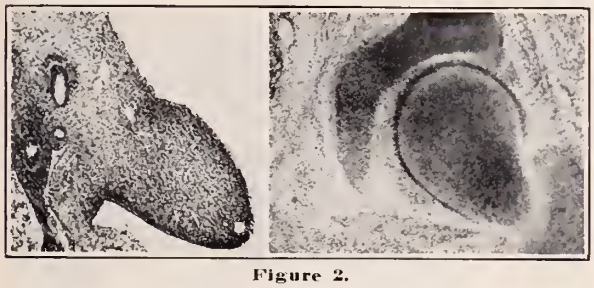

Figure 2.

Study of a typical unilateral congenital dislocation of the hip (figure 1) with obvious displacement of the femoral shaft laterally reveals that the acetabulum is shallow, under developed, and oblique in comparison to the normal opposite side.

I would like to review the present concept of the development of the hip joint. The microscopic section on the left in figure 2 is the lower limb bud of an 8.5 mm. embryo indicating a mass of undifferentiated mesenchyme. On the right there is a 28 mm. embryo showing differentiation of the femur and the innominate bone.

One is impressed by the orderly development of the undifferentiated mesenchymal mass into the design of the mature characteristics of the hip joint. It is felt that a delay in the innervation of the muscles about the hip or a delay in the rotation of the limb bud at a period of rapid growth may produce an alteration of the deepening of the socket and reciprocal changes in the head and neck of the femur. These changes may well be manifested by an abnormality in development in that there may be a shallow socket, an enlargement of the head as an attempt to accommodate it, increased torsion of the femur, and, if the abnormal forces are continued, even a subluxation or lateral drift of the head of the femur out of the hip socket.

It is an anatomical fact that the acetabulum and its margins are entirely cartilaginous at the time of birth (figure 3) and that the depth of the

Figure 3.

* Presented before the Section on Pediatrics at the One Hundred and Tenth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1951.

true acetabulum is greatly increased during prenatal life by the fibrocartilaginous structure called the limbus or glenoidal labrum. The limbus is nicely demonstrated in figure 4 which is an x-ray above and an air study below following dissection of a term, stillborn fetus.

The basic phenomenon in anomalies of the hip joint is an alteration of the growth and maturation of the acetabulum, and by reciprocal forces, an alteration of the femoral head. The degree of alteration of these parts is dependent upon the degree of alteration of growth. One might have abnormalities during intrauterine life sufficiently mild to recover spontaneously, proceed in their development, and be born with normal appearing hips. There may be all stages of maldevelopment from mild alterations of normal through the stage of dysplasia to a complete dislocation of the hip.

Figure 4.

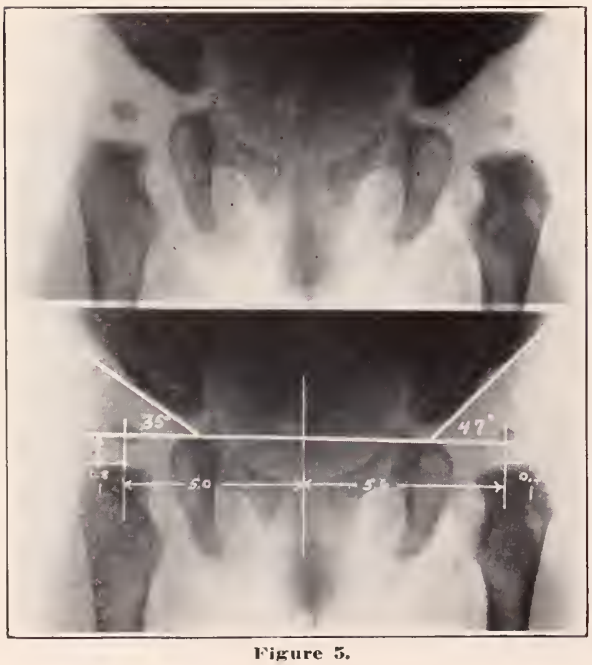

Figure 5.

It is felt that the dynamic forces of reciprocal development between the acetabulum and femoral head are well founded and are easily demonstrated. The two cardinal diagnostic features of hip joint abnormalities preceding dislocation are (1) Hypoplasia of the bony nucleus for the epiphysis of the head of the femur, and (2) Increased angulation of the acetabular roof.

Congenital dislocation of the hip was at some previous period a potential dislocation. The stage of hypoplasia of the femoral head and of increased angulation of the acetabular roof is the period of potentiality to which is referred. Figure 5 with diagrammatical markings below indicates these diagnostic features. If the alteration occurs early in prenatal life, the drift of the femoral head may well occur during intrauterine life, and the baby born with a lateral displacement of the femoral head known as congenital dislocation. If, however, the processes are later and the baby born without the lateral drift, then we designate the anomaly as a "dysplastic hip."

The basic phenomenon in anomalies of the hip joint is an alteration of the growth and maturation of the acetabulum and by reciprocal forces an alteration of the femoral head. Dislocation is a secondary phenomenon and need not necessarily occur. The dysplastic hip, with a flat or shallow socket, may persist throughout life usually with late degenerative arthritis as shown in figure 6, or a partial dislocation may occur and may gradually cause disability many years later as shown in figure 7.

The following cases that are to be presented are those cases in which the signs are usually considered insignificant but which it is felt, if allowed to go unobserved and sometimes untreated, cause changes

Figure 6.

Figure 7.

which are major, permanent, and irreversible later in life. What, then, is mandatory if we are to prevent permanent damage? The early recognition of dislocation, to be sure, but also the early recognition of the dysplasia and adequate treatment.

Clinically, patients with dysplasia and/or dislocation manifest a derangement of the hip joint by limitation of motion, usually limitation of abduction as shown in figure 8. A limitation of motion through any joint indicates a derangement of that joint. Infants with limitation of motion of one hip or both hips, whether it is associated with abnormal x-ray findings or not, should be treated to institute normal joint motions before the joint can be designated as normal. The x-ray findings are easily interpreted by a shallow buttress or increase in the so-called acetabular index as indicated in figure 5. The normal or average is 30 degrees, but it is granted that there are many degrees of dysplasia and variants which are within a normal range; but if there is a tendency toward obliquity, the case should be re-examined at a later time, but prior to weight bearing.

Forces producing a drift of the femoral head laterally to a dislocated position are intrauterine malposition and abnormal muscle forces over which we have no control. The force following delivery that produces drift is weight bearing. This is easily understood in that if the acetabulum is shallow and the limbus under-developed the femoral head can easily be "helped" out of the socket by weight bearing.

Figure 9 (top) is an x-ray of an infant four weeks of age taken because of limitation of motion of the right hip. The x-ray is difficult to interpret, but it appears that the acetabula are normal and the femoral shafts are in a normal relationship to the acetabula. The right femur is adducted, the left abducted. No treatment was instituted and figure 9 (bottom) is an x-ray taken at the age of 13 months following a limp on weight bearing, revealing an obvious, complete dislocation of the right

Figure 8.

femoral head with the typical immaturity of the femoral head and obliquity of the acetabulum.

It is indicated, therefore, that the diagnosis of dysplasia is based on the clinical finding of limitation of motion of a hip—a derangement—and a variant from the normal configuration of the acetabulum by x-ray. The diagnosis before the third month is difficult because clinically there may still be some normal, infantile limitation of motion remaining—but this is usually symmetrical—and the bony acetabulum may not be well enough ossified to outline a border line case. It is to be emphasized that it is obligatory that questionable cases be observed and re-examined prior to the weight bearing period at which time there should be no question as to diagnosis.

The most fundamental teaching in orthopedic surgery is the early recognition of and early treatment of congenital deformities. The early diagnosis and treatment of congenital dysplasia of the hip is certainly no exception. In early infancy the only positive clinical finding is limitation of motion of that hip. The limitation of motion limits the forces tending toward normal development of the hip joint and should be corrected at once. It is further stated that the earlier treatment is started, the less resistant and fixed are the contractures—an ideal time and treated with a simple device. The pillow abduction splint, (figure 10), perfected by Frejka of Czechoslovakia allows the gradual increase in motion of the hips to a normal range, thereby placing the femoral head opposite the acetabulum so that muscle force and position stimulate the deepening of the acetabulum and return the architecture to normal.

Two cases representing these thoughts are presented. The first case is of a normal infant female seen at six weeks of age with limitation of motion of the left hip in abduction, the left 35 degrees and the right 70 degrees. X-rays (figure 11, top left) reveal obliquity of the left acetabulum but no apparent drift of the femoral shaft laterally. A Frejka splint was applied and worn day and night. Re-examination revealed a return to normal symmetrical hip motions in one month. Repeat x-rays in five months (figure 11, top right) revealed symmetrical acetabula and maturation of the femoral heads.

The second case was seen at ten weeks of age with limitation of motion in abduction—the left 30 degrees and the right 40 degrees. X-rays (figure 11, bottom left) revealed an obliquity of both acetabula. The patient was treated in abduction casts and later

Figure 9.

Figure 10.

Figure 11.

a Frejka splint. X-rays (figure 11, bottom right) six months later revealed a mild alteration of the acetabulum and an immaturity of the femoral head on the left.

In summary may I reiterate my theme—congenital anomalies of the hip joint begin as an intrauterine alteration in maturation. The initial phenomenon is an alteration of the acetabulum which may persist, *per se*, or, if the processes continue, may result in a drift of the femoral head to a dislocated position. The child may be born at any time during this sequence—if the hip is dislocated, let us make the diagnosis early before fixed changes occur which will complicate treatment. If the child is born in the stage of dysplasia with a shallow acetabulum, let us recognize the entity and return the hip joints to normal as early as possible, thus avoiding any of the sequelae—dislocation with its long period of hospital and cast care, late degenerative changes due to incongruous articulating surfaces, and gradual displacement of the femoral head over a period of years.

425 East Wisconsin Avenue.

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WISCONSIN TRUDEAU SOCIETY FALL MEETING ANNOUNCED

The plans for the fall meeting of the Wisconsin Trudeau Society were recently announced. The meeting will be held in Madison at the Veterans Administration Hospital on October 24 and 25. Sessions will be held Friday afternoon (24th) and Saturday morning only.

The Treatment of Migraine and Migraine-Like Headaches With EC 112 Suppositories*

By M. C. F. LINDERT, M. D.**
Milwaukee

A GREAT need has existed for a mode of treatment for migraine and migraine-type headaches which would obviate the use of parenterally administered drugs and which would not aggravate the commonly occurring nausea and/or vomiting. Such a method of management is available in EC 112* rectal suppositories. This preparation contains 2 mg. of ergotamine tartrate and 100 mg. of caffeine. Encouraging reports have been presented by Blumenthal and Fuchs,[1,2] Kadish,[3] Ryan,[4,5] and Cohen and Criep.[6] Serious side reactions were reported as uncommon,[2] and undesirable reactions could be eliminated by a reduction of the dose.[3]

The purpose of this paper is to report experiences with this product used in patients whose headaches were not controlled by the usual management for migraine and all of whom were referred for internal medical consultation.

CASE 1.—R.M. was a 52 year old white female, who was first seen Oct. 24, 1949, at which time she stated she had had "migraine headaches practically all her life." Headaches were rather constantly accompanied by nausea, vomiting, vertigo, and occasional visual disturbances. The course and severity of her headaches were definitely aggravated by menopause following hysterectomy in 1936 and by development of a duodenal ulcer in 1944. Oral medications invariably resulted in exacerbation of symptoms from the latter condition. She had gradually lost weight from an average 120 pounds to 106 pounds, which was her weight, with clothing on Oct. 24, 1949.

An upper gastrointestinal barium meal x-ray study on Oct. 27, 1949 revealed peptic ulcer deformity of the first portion of the duodenum, non-obstructive. Therapy was immediately instituted to control her ulcer symptoms and simultaneously she was given EC 112 rectal suppositories for the control of her headaches. She reported excellent results on her next visit on Dec. 27, 1949. She has continued with this management for the past 27 months. Her present weight is 133 pounds, and there has been no serious recurrence of her ulcer symptoms.

Comment: This case illustrates a situation where a rectally administered medication served a twofold purpose, namely that of not aggravating the symptoms of nausea and vomiting, and secondly, that of aiding in the control of an active duodenal ulcer. Similar cases with gastrointestinal disease are not uncommon.

CASE 2.—E.S. was a 37 year old white female, who was first seen April 17, 1948, complaining of severe headaches of 15 years' duration. Headaches occurred at least one time per week, totally incapacitating her so that she could not carry on her duties as a school teacher in a parochial school. Accompanying symptoms included nausea, retching, and palpitation, but no dizziness or visual disturbances. Oral medications, including Gynergen, Cafergot (formerly Cafergone), etc., were totally ineffective. Parenteral administration of DHE 45 would shorten her incapacitations. The patient was reluctant to administer the medication to herself and relied upon a sister for the injection. Many times there was a delay of several hours before treatment was given. On Sept. 17, 1948, she was started on EC 112 suppositories, with excellent relief. She encountered mild side reaction, namely, that of palpitation, mild nausea, and post-headache exhaustion. For the past 27 months she has been repeatedly relieved for the acute attacks. The frequency of her attacks has been reduced, chiefly due to discontinuance of her work as a school teacher. She is presently employed as a stenographer and is not under any pressure.

Comment: This case represents a common situation in the management of migraine, that of intolerance to oral therapy and reluctance to self administer parenteral therapy.

CASE 3.—E.T. was a 50 year old white female, who complained of recurrent headaches since 12 years of age. Recently her symptoms had been aggravated and complicated by superimposed menopausal syndrome. Management of the latter condition was difficult because oral estrogen produced nausea and occasional vomiting. Treatment was interrupted every time a migraine headache occurred. She was started on EC 112 suppositories 15 months ago, with excellent results. Since her headaches have been controlled the menopausal syndrome has likewise been easily managed. The adequate therapy of her menopausal syndrome greatly reduced the frequency of the acute migraine attacks.

Comment: This case again illustrates the difficulty in control of a concomitant illness, which in this instance was considered a precipitating factor for migraine attacks. By means of rectal suppository treatment both conditions were adequately relieved.

*EC 112 (Two milligrams ergotamine tartrate and 100 mg. caffeine), supplied by Sandoz Chemical Works, Inc., New York 14, N. Y.

**From the Department of Internal Medicine of Marquette University School of Medicine, Assistant Clinical Professor of Medicine.

Case 4.—C.H. was a 41 year old white male chemical engineer, who complained of recurrent headaches since childhood. Each attack was characterized by head pain, nausea, vomiting, and visual disturbance. Nervous tension and anxiety aggravated the distress. The most severe episodes occurred when he was sent out of the city to inspect, evaluate, and buy metal materials for his manufacturing plant. He felt extremely inadequate in this duty because of a lack of training along this line while in college. Frequently he would be incapacitated for 36 to 48 hours before making his business contact. An attack of this type would leave him in an extreme state of exhaustion. He was started on EC 112 suppositories 32 months ago. Since treatment began he has *not* been incapacitated and attacks have been aborted in one to four hours. He has been able to carry out the most difficult assignment. The only side reaction was that of occasional rectal irritation.

Comment: This case illustrates the vital need for a rectal preparation to combat migraine headaches. Here a most gratifying result made it possible for the patient to hold a position which had repeatedly incapacitated him.

Summary

The 4 cases presented typify the series of patients treated with EC 112 rectal suppositories since June 1949. Twelve patients have been treated 12 to 32 months. Eight additional cases have been observed from 2 to 12 months. None of these patient's headaches had been adequately controlled by oral preparations of ergotamine tartrate. Everyone is aware of the disadvantages of parenteral therapy, chief amongst which is the patient's reluctance to self administer injectable substances. All patients treated had distinct relief of headache, most of which were on the dramatic side. Side reactions were few and minimal. Those experiencing side reactions chose to endure them in preference to the distressing symptoms of the acute attacks. Impressive results of this mode of therapy were especially exhibited in patients where concomitant illness was present, e.g., duodenal ulcer, gallbladder disease, and menopausal syndrome. The dosage schedule was simplified to the use of one suppository as soon as the patient realized that the characteristic features of a migraine headache were developing.

Conclusions: A rectal suppository of ergotamine tartrate and caffeine was observed to be an ideal, desirable, and efficient mode of treatment for migraine and migraine-type headaches.

5340 North Berkeley Boulevard.

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POSTGRADUATE CLINIC ON HEART DISEASE ANNOUNCED

Dr. Ovid O. Meyer, chairman of the postgraduate education committee of the Wisconsin Heart Association, announces a postgraduate clinic on heart disease for Wisconsin doctors.

The Faculty: Paul D. White, M. D., Consultant in Medicine, Massachusetts General Hospital, Boston, Mass.; Executive Director, The National Advisory Heart Council.
Alfred Blaloch, M. D., Professor of Surgery and Director of the Department of Surgery, Johns Hopkins University School of Medicine, and Surgeon in Chief, Johns Hopkins Hospital, Baltimore, Maryland.

The Time: Clinics will be held at the Marquette University School of Medicine in Milwaukee on Wednesday, October 22, and at the University of Wisconsin Medical School Auditorium in Madison on Thursday, October 23.

Description: Doctors White and Blaloch will conduct clinics in the afternoon on subjects furnished to them at the two medical schools. Each will give a formal presentation in the evening.
The title of Doctor White's talk in Milwaukee will be "Coronary Heart Disease," and his topic in Madison will be "Hypertensive Heart Disease." The doctor will also address the Milwaukee Academy of Medicine on October 21. He has chosen "Three Medical Eras" as his subject for this occasion.
The title of Doctor Blaloch's presentation will be "The Surgical Treatment of Certain Types of Cardiovascular Disorders."

These clinics are made possible through a special grant from the Wisconsin Heart Association and no fee will be charged. All members of the medical profession in Wisconsin are welcome.

Proceedings of the Milwaukee Academy of Medicine, April 22, 1952

The Management of Pain

By F. A. DUNCAN ALEXANDER, M. D.*
McKinney, Texas

IF ONE accepts the criterion that the current medical literature is an accurate and authentic reflection of current medical interest, this subject is a timely one.

At the risk of appearing anachronistic, I submit the thesis that this present trend represents a renaissance in medical interest directed toward a revival of the art of the practice of medicine as opposed to its scientific antipodes.

There is a curious paradox in this field that the two groups of physicians ordinarily most widely separated by interests and activities are probably equally adept and successful in the management of pain. I refer to the general practitioners whose knowledge of pain and its management probably exceeds that of any other group and, secondly, to neurosurgeons, some anesthesiologists, and some neurologists who have made pain their special interest.

The word phenomenon is used, unfortunately and loosely, in medical terminology to describe many occurrences which might better be termed as functions or mechanisms. In so far as pain is concerned, however, phenomenon is a truly appropriate word. One of the most significant of the discoveries concerning pain has been that it is a phenomenon of great complexity. The efforts of researchers in the past 10 years to discover and explain the intricacies of pain have been illuminating but only corroborative of what has long been known by the successful family physician. I refer of course to the fact that pain is primarily subjective and that, because of this subjectivity, it does not lend itself to investigation or evaluation by the laboratory means usually applied to other disease processes.

During the course of the last 6 years in a very intensive, long range study of pain in its various aspects, we have come to these conclusions:

1. It is impossible to divorce the psychologic, emotional, and cognitive aspects of pain from the sensation itself, and any efforts to do so are bound to result in conclusions which are at best equivocal.

2. Patients who have been long term complainers of pain almost inevitably believe that they have lost stature within their immediate family circles and their communities. If this has resulted in an assumption of a martyr complex or serious depression, the solution of the problem is more complicated.

3. The successful conduct of a difficult problem in intractable pain necessitates, above all, the availability of a physician who has the time and sympathy to completely investigate all the aspects of the problem. There is a great tendency to give lip service to psychosomatic theories and explanations. The professional psychosomatists have probably contributed no more than the psychiatrists to the solution of this problem. There is no substitute for taking the patient's history and sympathetic understanding in laying the groundwork for the solution of pain problems.

4. It is undeniable that progress has been made in methods for the identification of pain pathways and in their interruption—either with drugs or by surgery. In either of these cases, accuracy should be strived for by all objective methods available. Among the most advantageous of these is the identification of nerve block accuracy by roentgenograms with and without the use of contrast media.

5. Even under optimum circumstances one may be confronted with a situation in which it has appeared that all reasonable pain pathways have been interrupted and still the patient persists in his complaint. When that occurs, one cannot immediately assume that a psychosis or psychoneurosis is present. The patient should never be peremptorily abandoned to such a diagnosis with all of its implications.

6. All experienced physicians should be aware of the value of placebo medication, whether it takes the form of actual drug therapy or some procedure which is undertaken in good faith but actually has questionable basis in scientific fact. For that reason it is necessary to maintain a sympathetic attitude toward those patients who appear to have had an in appropriate response to placebo medication or procedures.

7. It is unfortunately true that there are circumstances in which it is necessary to abandon the sub-

(Continued on page 881)

*Chief, Anesthesiology at the Veterans Administration Hospital, McKinney, Texas; and professor of surgery, Southwestern Medical College of the University of Texas.

Reviewed in the Veterans Administration and published with the approval of the Chief Medical Director. The statements and conclusions published by the author are the result of his own study and do not necessarily reflect the opinion or policy of the Veterans Administration.

Clinicopathologic Conference

Editors—W. A. D. ANDERSON, M. A., M. D., Marquette University School of Medicine, Milwaukee and D. M. ANGEVINE, M. D., University of Wisconsin Medical School, Madison

PRESENTATION OF CASE*

History: This 34 year old housewife entered the hospital on September 27. She had been a known diabetic for 21 years and her diabetes was said to be controlled on a 2,100 calorie diet with 20 units of NPH insulin daily. During 7 years of marriage, she had had two pregnancies, both terminated by abortion. The last of these was five years preceding this hospital admission when at two months gestation it was noted that she had edema and albuminuria. She was unaware of the presence of hypertension at that time; however, she was placed on a low sodium diet and had been followed for nephritis subsequently. Some edema persisted, particularly in the ankles and feet but also about the face.

It was two months before this hospital admission when anorexia, nausea, vomiting, muscle twitching, pruritus, failing vision, headaches, and increased edema marked the beginning of the patient's downhill course. She was hospitalized for five weeks elsewhere, but, seemingly, her symptoms progressed in spite of parenteral fluid treatment. It had been noted that she was oliguric, that emesis contained blood and coffee-ground-like material, and that she was moderately dyspneic. The past history included the usual childhood diseases, without known sequelae, and furunculosis at the age of 20. There was no family history of diabetes.

Physical Examination: The patient was a well developed, chronically ill white female having evidence of obvious weight loss, generalized pallor, and a bronzing of the skin of the face. There was restlessness, frequent singultation, apprehension, and frequent muscle twitching. There was edema of the face and extremities; ecchymoses of the soft palate, legs, and left arm; hypoactive deep tendon reflexes; and many excoriations over the arms and legs. The blood pressure on admission was 180/115; pulse, 104; regular respirations, 24; and temperature 98.2 F.

Cardiac examination demonstrated the point of maximum impulse to be in the midclavicular line 9 cm. to the left of the midsternal line in the fifth intercostal space. An apical localized systolic murmur, tambour accentuation of the aortic second sound, and a gallop rhythm were also observed.

The liver edge was palpable six fingerbreadths below the right costal margin, and the abdomen seemed distended. Funduscopic examination demonstrated slight papilledema, more noticeable on the left; numerous hemorrhages, both flame and punctate type; and exudates scattered throughout both fundi, with venous distention and severe arteriolar spasm.

Laboratory Examination: On the afternoon of admission the blood sugar was 528 mg. per cent; the carbon dioxide–combining power was 46 volumes per cent. The urine contained 2 plus sugar but no acetone. Additional studies on the following day revealed the nonprotein nitrogen to be 144 mg. per cent; creatinine, 2.5 mg. per cent; sodium 140 milliequivalents per liter; potassium 5.22 milliequivalents per liter; chlorides, 87 milliequivalents per liter; calcium, 7.8 mg. per cent; and phosphorus 9.8 mg. per cent.

An electrocardiogram was interpreted as follows: sinus tachycardia, rate 100; P–waves in leads II and III slightly peaked; T_1 iso-electric; T–V_6 was very low; PR—0.19; QRS—0.07. Impression: lowering of T–waves consistent with coronary insufficiency. A bedside x-ray of the chest was interpreted: "There is no evidence of acute or significant pulmonary disease. There is a minor amount of pleural thickening at the apices."

Course: Therapy, directed toward ever evident dehydration, consisted largely of intravenous and/or subcutaneously administered 5 per cent glucose in distilled water and 20 to 30 units of regular insulin per liter of fluid. The over-all blood chemistry suggested an increasing sensitivity to insulin.

The clinical course, culminating in death, was characterized by increasing mental confusion and extensor spasms of the extremities as well as increased muscle twitching, stertorous respirations changing to Cheyne–Stokes respirations, orthopnea, and grossly audible rhonchi. A lumbar puncture, initial pressure 160 mm. of water, temporarily reduced muscle irritability, whereas frequent intravenous calcium gluconate had little appreciable effect. A pericardial friction rub was never audible, but the breath had a uriniferous odor at all times.

A beside chest x-ray on October 11, the day of death, was interpreted: "Since the film of September 28, there has developed considerable hazy loss of aeration in the lung fields. There are soft shadows throughout the left central and basal lung and similar but less marked changes on the right. Extreme apical and basal peripheral zones are clear. The diaphragm is well visualized with no evidence of pleural fluid. The heart size and shape have not changed since the previous film; it is within the upper limits of normal in size."

Clinical Discussion

Dr. T. H. Lorenz: The problem today is that of a 34 year old woman who had been a rather mild

*From the University Hospital and University of Wisconsin Medical School.

diabetic, supposedly controlled on a 2,100 calorie diet and 20 units of NPH insulin since she was 13 years old, and who, following her second spontaneous abortion five years before she was admitted here, was treated by her local physician for nephritis. According to the history, this label was attached to her condition due to edema about the face as well as the extremities, albuminuria, and possibly hypertension. Later, what seems to have been uremia developed. In spite of hospitalization and therapy elsewhere her condition deteriorated, and she died two weeks following admission to this hospital.

It seems to me that this patient presented a much greater therapeutic problem than a diagnostic one. I think the same thing holds true now. It is my impression that this patient had Kimmelstiel–Wilson syndrome or disorder, the so-called intercapillary glomerulosclerosis, and that she died primarily of renal failure.

Some of the points in the history and physical examination, etc., that I have used to arrive at this conclusion should be mentioned. First of all, she was a long-standing and rather mild diabetic case. It is in this type of diabetes that Kimmelstiel-Wilson disorder is usually found. There is a significant absence of other diseases in her past medical history, particularly those that have any reflection on kidney function. The only disorder that was noted in her past history was furunculosis which was certainly to be expected considering the fact that she was diabetic. There was a history of two abortions which is not particularly surprising since stillbirths and other complications of pregnancy occur six times more commonly in the diabetic than in the non-diabetic mother. Toxemia of pregnancy also occurs with greater frequency in diabetes. This may have been a factor in the occurrence of her abortions. Thus, this complication may have been an added stress to her already somewhat deficient renal status. The patient was treated for five years for so-called nephritis, and there was nothing too remarkable about this until two to three months before admission here when she manifested symptoms of chronic renal failure with anorexia, nausea, vomiting, muscle twitching, itching, failing vision, headaches, and edema of the face and dependent portions of the body. Bleeding from the gastrointestinal tract also developed, with progressive dyspnea and oliguria.

On physical examination it was noted that the patient was chronically ill and malnourished but afebrile. The malnourishment is no mystery when one considers the fact that she had been vomiting, that she had no appetite, and that there probably was great protein depletion. She was pallid. This is to be expected since anemia is so characteristic of chronic renal failure. There was a note that there was bronzing of the skin which is not unusual in chronic renal failure and is attributed to the oxidation of urochromogen to urochrome in the skin which is exposed to light. This pigment is the one which ordinarily gives urine its yellow color. It was noted that the patient was restless, apprehensive, and had twitching muscles. These are all signs of the irritative phenomena that go with uremia. The basis for these is really unknown, but some attribute them to a decrease in ionized calcium due to phosphate retention.

Later on there was some comment to the effect that she was somewhat confused. The signs of confusion, stupor, and coma are some of the depressive central nervous system reactions which frequently accompany uremia, and although unexplained, they are believed due to the retention of phenols. There was hiccoughing which is characteristic of uremia. The distribution of the edema was characteristic, facial as well as in the extremities. We know that she had ecchymoses of the skin and can assume similar alterations in the gastrointestinal tract as well. These are unexplained but also characteristic of uremia. There were excoriations of the skin which imply that there was a pruritus. This too is unexplained but often found in uremia. It could also be attributed to her diabetes when the blood sugar is elevated as hers was on admission.

Funduscopic examination revealed severe retinopathy which is attributable to any one or a combination of three factors: diabetes, advanced renal disease, or hypertension. Also it was noted that there was slight papilledema. This was not surprising considering the possibility of increased intracranial pressure and encephalopathy. As far as the cardiovascular system was concerned, the patient was hypertensive with a pressure of 180/115 mm. of mercury. She had tachycardia but no other arrhythmia. There was no description of the type of respirations which were 24 per minute. The cardiac findings were consistent with those of hypertensive cardiovascular disease. She had borderline cardiomegaly and an apical systolic murmur with tambour A_2; she had gallop rhythm which is not further described, but we could probably attribute this to a decreasing cardiac reserve.

There was no comment about the pulmonary examination at the time of admission. We can assume, therefore, that her lungs were clear. I think this point is pertinent because it was noted that she had hepatomegaly and edema. I think we can base her hepatomegaly on the fact that she had diabetes and probably a fatty liver, rather than on a cardiac basis. Likewise, with the abdominal distension it was probably a combination of ascites and tympanites.

In regard to the laboratory data, there was no reported urinalysis. This is a minor oversight I imagine, and it seems a bit paradoxical, but actually it is not. I think this case is so obviously one of uremia that one does not even need a urinalysis to prove it, yet it would be somewhat helpful. There is no comment about a complete blood count so that one is at a loss to confirm the presence of anemia. Likewise, there is no comment about serum proteins, but I will wager that she had hypoproteine-

mia. The data that are available indicate that she was in rather poor diabetic control when she came in but not greatly so. There was no acetone in the urine, and the carbon dioxide was only slightly below the lower limits of normal. Her azotemia was considerable, nonprotein nitrogen 144 mg. per cent, with a markedly elevated creatinine. From the electrolyte standpoint things could have been worse. She had a rather marked increase in inorganic phosphorus and a moderate decrease in calcium. The chlorides and potassium were slightly altered, whereas the sodium was within normal limits. The electrocardiogram was notable mainly for the absence of any changes which might signify electrolyte disturbance. Certainly the presence of some coronary insufficiency is not surprising in a patient with the illness that this individual had.

The first x-ray of the chest supports the impression that cardiac decompensation was not in the picture. There was no evidence of significant pulmonary congestion. On the second chest x-ray the changes were characteristic of those found with uremia and renal failure which is further evidence, I believe, that the primary cause of death in this instance was renal decompensation and failure. Despite efforts to improve the kidney function and assist her pancreas and heart, she went on to die. Unfortunately, this was a foregone conclusion considering her status on admission.

I believe on necropsy that it might be found that the patient had intercapillary glomerulosclerosis. The possibility of a necrotizing papillitis exists since this occurs particularly in uncontrolled diabetics, yet I think that papillitis is not likely nor necessary to account for the clinical picture or her death. I also think that there will be found some encephalopathy and possibly increased intracranial pressure. The latter is dubious because on spinal tap the pressure was not increased, yet with spinal tap her symptoms of central nervous system irritability were somewhat temporarily reduced. I think there will also be some pulmonary congestion, possibly a terminal pneumonitis, hemorrhagic changes in the gut, with probable ulceration in the upper gastrointestinal tract, and a fatty liver. One would also expect changes in the pancreas that are found sometimes in diabetes and probably cardiac hypertrophy with some myocardial scarring on the basis of coronary arteriosclerosis.

Dr. Wayne Rounds: A bedside film taken about the time of admission showed a cardiac shadow at the upper limits of normal in size. The pulmonary parenchyma was clear. There was a minimal amount of apical fibrosis. A film taken about 2 weeks later showed a clouding of the central portion of the lung. The heart at this time was about the same size as on the previous film. The sulci, the periphery of the lung fields, the apices, and the parenchyma in the apices were relatively clear. This type of density, as Doctor Lorenz states, is usually due to the renal causes.

Necropsy Findings

(W.G.H. 51:242)

Dr. J. J. Lalich: There was pitting edema of the lower extremities. When the peritoneal cavity was opened, 600 cc. of yellow fluid was found. In the thorax the mediastinal structures were in the midline, and there was no pleural effusion. The heart was only slightly enlarged but normal. There were scattered lipid plaques in the coronaries, but these were not very large. Since this was a severe diabetic case, we were interested in the degree of arteriosclerotic involvement of the aorta. There were very few plaques in the thoracic aorta, and there was some thickening of the abdominal aorta, but on gross inspection one would certainly place this between normal and minimal involvement.

The lungs were moderately to severely involved with acute pulmonary edema and congestion. In the bronchi there was frothy material which one would expect with pulmonary edema. Nothing unusual was found on the spleen. The liver weighed 1,470 Gm. I suspect that the clinical impression of liver enlargement was due to ptosis of the liver. The edge was 8 cm. beneath the right costal margin. The pancreas measured 22 by 3 by 1.5 cm., which is approximately normal. When cut across, the usual irregular lobular structure was evident. The lobules were apparent, and there was no evidence of fibrosis or distortion of the lobular pattern. Sections were taken for microscopic study from the head and the tail of the pancreas.

Each of the kidneys weighed 140 Gm., which is slightly low but within normal limits. The organs, however, were pale. The capsule stripped with some difficulty, leaving a uniformly granular surface. The cortical medullary junction, however, on cut surface was distinct, and peculiarly enough, the cortex was of the expected dimensions, which is 7 to 8 mm. One peculiarity about the renal cortex was that it was yellower than ordinary. The medulla was congested. The pelves and ureters were not involved. We did not find any evidence of parathyroid hyperplasia secondary to chronic kidney disease. Most of the findings in this case were of a microscopic nature, and we have sections from the head and tail of the pancreas and from both kidneys.

There was increased fibrosis about the pancreatic duct and around blood vessels. In a random section of pancreas with an area of 1 by 2 cm., one would expect to find approximately 10 to 25 islets. In the examination of two sections, one from the head and one from the tail, we did not find one typical islet of Langerhans. We did find, I believe, just two islets in each section, and these were atypical. The cells seemed to be smaller than ordinary, and there was not as much cytoplasmic material. Furthermore, the islets were of smaller diameter than usual.

In addition to decreased numbers and atypical islets and fibrosis about the blood vessels and ducts, we also observed dilated acini which could be due to either atypical islets or dilated pancreatic ductules.

In the kidneys we observed what Doctor Lorenz felt was the cause of this person's difficulty. Microscopic examination indicated that practically all of the glomeruli were involved to some degree with fibrosis or hyalinization. Judging from the degree of hyalinization, many of the glomerular tufts were markedly handicapped functionally. In addition to the rather extensive involvement of the glomerular tufts you will be impressed by the relative absence of tubules in the cortex. The tubules have been replaced by a rather diffuse connective tissue and a few lymphocytes. However. the latter were not a very conspicuous feature. The type of glomerular fibrosis which has been described by Kimmelstiel-Wilson is not too apparent here. What he described is a spheroid of hyaline with peripheral placing of the nuclei. We have observed suggestions of that in several of the glomeruli; however, this feature was uncommon. In some areas the remaining tubules had undergone hyperplasia. With a disappearance of tubular mass one may observe some hyperplasia in the remaining nephrons.

The thyroid gland with the attached parathyroids contained only a few "Wasserhelle" cells in the latter. In conclusion, we thought that this person had diabetes mellitus which was responsible for the nephrosclerosis of the arterial and arteriolar types. There was a glomerulosclerosis of a severe type due to diabetes. Due to the above changes there was edema and congestion of the lungs with ascites and a terminal uremia.

Question: What did you find in the aorta?

Dr. J. J. Lalich: We found minimal amounts of lipid in the intima of the thoracic aorta and moderate intimal involvement in the abdominal aorta. At both sites there were also intimal lipophages.

Dr. O. O. Meyer: You said glomerulosclerosis due to the diabetes. Do you feel that one can say without equivocation that the glomerulosclerosis is due to diabetes?

Dr. J. J. Lalich: Well, I believe, Doctor Meyer, that when one has a lesion of this type, you are confronted with the differential diagnosis of chronic glomerulonephritis, the effects of a severe arteriolosclerosis, and the possibility of bilateral pyelonephritis. I think that even in the most advanced arteriolar nephrosclerosis we still do not have as uniform and extensive glomerular sclerosis as is present in this case. In so far as chronic glomerulonephritis is concerned, we searched in vain for the presence of crescents and distortion or alteration of Bowman's capsule. The paucity of leukocytic infiltration in the interstitium and the absence of medullary and pelvic involvement made us feel that we were not dealing with pyelonephritis. For these reasons, largely of exclusion, we consider it to be diabetic glomerulosclerosis.

Dr. D. M. Angevine: I do not believe that I can settle the problem. Opinions have vacillated first one way and then the other. Certainly, this hyaline glomerular lesion is much more commonly associated with diabetes. In the diabetic there is a much more profound arteriolar sclerosis than in the nondiabetic.

One thing that might be pointed out in relation to the changes of the pancreas in diabetes is that alterations observed in this case are not the usual finding. The usual finding in the diabetic, of course, is hyalinization of the islets. Here there are no islets, and I suspect that this is a congenital absence because they have not been destroyed by fibrous connective tissue. In a rare case of a child with a diabetic mother, we find hyperplasia of the islets. In congenital diabetes we often find an absence of islet tissue.

Question: Was the liver fatty and was the central nervous system involved?

Dr. J. J. Lalich: The brain was removed, and on gross examination we did not observe anything of significance. A microscopic examination was not done. The liver was of a yellowish color. On microscopic examination, however, we did not have extensive vacuolization of cytoplasm in the liver cells. We did find pale and vocuolated nuclei in the liver cells such as occur in diabetes.

Dr. F. C. Larson: Did you stain the liver for glycogen?

Dr. J. J. Lalich: No we did not. I think that it is interesting to point out that in the diabetic you do find increased amounts of glycogen in the renal tubules. I would like to add that it is very difficult for the clinician to postulate the exact morphologic changes in the pancreas from clinical observation of the patient. Of the changes which may occur, Doctor Angevine has mentioned hyalinization and a deficiency in the number of the islets. Other changes capable of producing diabetes are hydropic degeneration, necrosis of the islets, and lastly, fibrosis with lymphocytic infiltration of the islet. Now, in so far as how much destruction of the pancreas has to occur, I believe around five-sixths is the accepted figure. It may be of interest to point out that the islets and the pancreatic acini have different blood supplies so that marked destruction of acini does not affect the islet tissue.

I would like to ask the clinicians one question. If you remember, Doctor Lorenz said of course she had furunculosis, implying that is a common observation. I would like to ask Doctor Meyer whether he has any ideas as to why this should occur.

Dr. O. O. Meyer: I do not know why. The commonly offered, long-standing theory is that because of increased sugar there is a better medium for bacterial growth and multiplication and also lessened resistance within tissues.

Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

Misuse of Antibiotics

The accusation has been made that in this era of antibiotics some physicians occasionally "first treat, and if the patient does not get well, then attempt to diagnose." This practice may even be demanded by the patient himself or his family, who, having read in the popular magazines about the marvels of the antibiotic drugs, feel that without their use the attending physician is either misinformed or neglectful.

The dangers of uses and abuses of the antibiotics are coming more and more to the fore with the more extensive experiences gained in the period of time since these drugs were introduced into therapy. As we all know, practically any substance, even water, absorbed in excessive amounts, can produce harm. The amount required to produce harm may vary enormously from person to person and even in the same person at different times. Sensitivity to an absorbable substance often increases to manifest itself through simple overactivity or as an allergic phenomenon.

The effects of these drugs may be manifest by a disturbance in what we may consider as a normal balance of the microorganisms themselves which are normally present. An example of this imbalance is the uncontrolled growth of molds or fungi through the removal or diminution of those organisms susceptible to the antibiotics and which would appear normally to keep them in check, possibly through the production of antibiotics effective on these molds. A now common observation is the marked increase in growth of molds or fungi in the lower intestinal tract and mouth which often manifest themselves by symptoms suggestive of pellagra.

A study of hospital personnel, aides, nurses, interns, residents and attending physicians has revealed the harboring of more and more strains of potentially harmful bacteria which have become relatively non-susceptible to the now available antibiotics, or at least to those antibiotics employed. The evidence, furthermore, points to a significant development of cross-tolerance by bacteria to antibiotics to which they have not even been exposed. This means that a tolerance developed through exposure to one antibiotic may be concurrent with a tolerance to a different antibiotic to which the bacteria have not been exposed so far as is known. Thus, one must realize that strains of bacteria which are resistant to antibiotics are being unwittingly cultivated *in vivo* to be passed on to other persons, perhaps with dire results.

Evidences are beginning to appear to the effect that certain of the antibiotics actually stimulate the growth of fundi, e.g., Candida albicans *in vitro*, thus more or less spontaneously paralleling a strain of meningococci, as reported by Miller, which not only became tolerant to, but even became vitally dependent upon, a member of the series of antibiotics.

We should recall the age old fact that, by and large, people "got well" and survived in the era prior to the antibiotics. This was evidently due to the development of tolerance by man to the many infective agents. There is no doubt whatsoever that the careful use of these drugs has been of great value in that smaller proportion of cases in absolute need of antibiotic aid to natural defenses. On the other hand, the promiscuous use of these emergency agents is fraught with obvious dangers which should be most seriously considered. It might be well to ponder the reasons *why such drugs should not be used* in each and every case, and if none is really valid, then proceed with care, giving just that dose of the antibiotic which is safe for the patient but which is fatal, directly or indirectly, to the invading pathogenic microorganisms.—A. L. TATUM, M. D.

REFERENCES

1. The dangers of antibiotics, M. J. Australia 1:869, 870, 887, 894, and 896 (June 28) 1952.
2. Miller, C. P.: Development of bacterial resistance to antibiotics, J.A.M.A. 135:749–751 (Nov. 22) 1947.

MANAGEMENT OF PAIN

(Continued from page 876)

ject to a regimen of narcotics. When that occurs, the patient deserves to be given the narcotic which will give him maximum relief and satisfaction with the minimum side effects. This is impossible to predict and, therefore, if this course is decided upon, the patient should be given at least three or four of the drugs for three day intervals and the ultimate choice made his responsibility. In spite of the orthodox teaching of pharmacology, it has been our experience that the actual use of the drugs can be safely left to the discretion of the patient and that the orders for its use can be written "on demand" rather than "p.r.n.q.4 h." Another procedure which has proven to be valuable in our hands is the combination of narcotics with a basic sustaining dose of phenobarbital given much in the same manner as one would give digitalis and combined with the use of such drugs as desoxyn or benzedrine in the early mornings.

8. The problem of the patient with intractable pain is universal and one which confronts all physicians. Under such circumstances an effort should be made to identify the pain pathways involved. When they have been delineated, the successful solution of the problem should be undertaken by prompt, bold, definitive measures strategically based upon knowledge available to all of us.

Scientific Programs of Special Groups

WISCONSIN CHAPTER American College of Chest Physicians

HOTEL SCHROEDER — SUNDAY, OCT. 5

1:00 p.m.: REGISTRATION AND VIEWING OF EXHIBITS: 5th Floor

2:00 p.m.: SCIENTIFIC PROGRAM: Crystal Ballroom: 5th Floor

PROBLEMS IN THE DIAGNOSIS OF CHEST DISEASE: Herbert W. Schmidt, M.D., Rochester, Minnesota

CLINICAL DIAGNOSIS AND TREATMENT OF EMPHYSEMA IN THE PATIENT PAST FORTY: Edwin R. Levine, M.D., Chicago

TUMORS OF THE CHEST IN CHILDREN: Gorton Ritchie, M.D., Milwaukee

TREATMENT OF INOPERABLE CANCER OF THE LUNG: Edgar Mayer, M.D., New York City

PRECORDIAL MIGRAINE: John F. Briggs, M.D., St. Paul, Minnesota

6:00 p.m.: DINNER: Club Rooms, 3rd Floor

Address: CLINICAL APPLICATION OF RECENT ADVANCES IN CARDIOPULMONARY PHYSIOLOGY: Aldo A. Luisado, M.D., Chicago

Wisconsin Society of Anesthesiologists

HOTEL SCHROEDER — SUNDAY, OCT. 5

2:00 p.m.: BUSINESS MEETING

3:30 p.m.: RESUSCITATION IN THE OPERATING ROOM: Claude Beck, M.D., professor of cardiovascular surgery, Western Reserve University School of Medicine, Cleveland

(This will be the same subject as Doctor Beck will discuss at his round table luncheon on Monday, but, as this luncheon is completely filled, all physicians interested in the subject are urged to attend this Sunday meeting.)

5:30 p.m.: SOCIAL HOUR

6:30 p.m.: DINNER

1952 Annual Meeting

MILWAUKEE—OCTOBER 6-7-8

Annual Meeting Announcements

- REGISTRATION: Secure your badge at the registration desk, inside of main entrance of Milwaukee Auditorium, Kilbourn Street. Registration hours: Monday and Tuesday: 7:30 a. m.–4:30 p. m.; Wednesday: 8:00 a. m.–12:00 m. *Admittance by badge only.*
- CERTIFIED GUESTS: Medical students and hospital personnel admitted on Wednesday, *if previously certified,* or presenting proper credentials. Residents and interns admitted without registration fee, if properly certified by hospital. Out-of-state physicians who are full dues-paying members of their county and state medical societies admitted by presenting their membership cards.
- DELINQUENT MEMBERS OR NON-MEMBERS: Admitted by payment of $10.00, which will be refunded if full dues are paid through county medical society within six months following Annual Meeting.
- VA AND MD'S IN MILITARY SERVICE: Members of Veterans Administration must be full dues-paying members to be admitted. Those physicians in armed services admitted by presenting certification of current military service.
- TELEPHONE SERVICE: *At Milwaukee Auditorium:* During scientific sessions, calls to physicians other than Milwaukee doctors should be directed to special phones installed at the registration desk. The number is Broadway 2–2597. Calls for Milwaukee doctors should be directed through Physicians Service Bureau (Marquette 8–4131), and they will be transmitted to a special phone in the Auditorium located near the main meeting room. A staff member of the Medical Society of Milwaukee County will be in attendance to receive the calls. *At the Hotel Schroeder:* Delegates can be reached during sessions of the House (Sunday, Oct. 5, from 2:30–5:00 p. m.; Monday, Oct. 6, from 6:30–8:30 p. m.; and Tuesday, Oct. 7, from 9:00–10:00 a. m.) by having calls directed to the phone on the fifth floor foyer of the Hotel Schroeder (Marquette 8–7250). Those attending luncheons can be reached in the same manner between 12:15–2:15 p. m. each of the three days of the meeting. *If you are attending luncheons, inform your secretary of your schedule, so you can be located promptly if you are to be called.* Give your secretary the name of the round-table leader, and the number or letter of the room where the luncheon will be held.
- RESERVATIONS FOR ROUND TABLES AND DINNER: Reservations for round tables and dinner at registration desk in Milwaukee Auditorium from 8:00–11:00 a. m. Between 11:30 a. m. and 12:15 p. m. each day reservations can be made in fifth floor foyer of Hotel Schroeder.
  If you have left your dinner and luncheon tickets at home, duplicates can be secured at locations noted above. *No one may attend a luncheon or the Annual Dinner without a ticket.*
- SPECIAL LUNCHEONS AND DINNERS:

  Sunday, Oct. 5
  International College of Surgeons: Parlor G, Hotel Schroeder, 6:00 p. m. Contact John Sprague, M. D., 109 E. Johnson St., Madison, for dinner reservations.

  Monday, Oct. 6
  Past Presidents: Parlor G, Hotel Schroeder, 12:15 p. m.
  "Legal Aspects of Medical Practice:" East Room, Hotel Schroeder, 12:15 p. m.
  (C. C. Schneider, M. D., and Mr. Kenneth Grubb, Milwaukee, discussants.)
  Washington University Alumni Dinner: University Club (Cocktails at 6:00 p. m.). Contact C. M. Schroeder, M. D., 208 E. Wisconsin Ave., Milwaukee, for reservations.
  Wisconsin Medical Women's Society Dinner: Matthew Keenan Health Center, 3200 N. 36th St., at 6:00 p. m. For details of program and specific plans for dinner write Elaine M. Thomas, M. D., 200 E. Wells St., Milwaukee.

  Tuesday, Oct. 7
  M. D. Office Procedures: Hotel Schroeder, 12:15 p. m.
  Clinic Managers: Club Rooms, Hotel Schroeder, 12:15 p. m.
  Medical Examiners of CAA: Hotel Schroeder, 12:15 p. m.
  Marquette Alumni Association: Complimentary Luncheon at Blatz Brewery, 12:00 p. m. Tickets obtainable at Marquette Alumni Office, 1533 W. Wisconsin Ave., Milwaukee.
  Pathologists: Pere Marquette Room, Hotel Schroeder, 12:15 p. m.

  Wednesday, Oct. 8
  EENT Physicians: East Room, Hotel Schroeder, 12:15 p. m. (Program at 1:30 p. m.)
- SPECIAL PRE-CONVENTION SCIENTIFIC PROGRAMS: Sunday, Oct. 5: *Chest Physicians:* Scientific program beginning at 2:00 p. m. in Ballroom, Hotel Schroeder. Dinner in Club Rooms, Hotel Schroeder at 6:00 p. m. *Wisconsin Society of Anesthesiologists:* 2:00 p. m., scientific program, South Room, Hotel Schroeder; dinner at 6:30 p. m., Parlor A, Hotel Schroeder.
- MEDICAL GOLF TOURNAMENT: The annual Medical Golf Tournament will be held at the Bluemound Country Club, Milwaukee, on Wednesday, Oct. 8. Tee-off time will be at 1:00 p. m., and Dinner and presentation of awards at 6:30 p. m. If you have not already made reservation for this event and wish to participate please contact Mr. A. H. Luthmers at the Medical Society of Milwaukee County, Bankers Bldg., Milwaukee.

DAILY TIMETABLE OF EVENTS

1952 ANNUAL MEETING MILWAUKEE, OCT. 6, 7, 8

Sunday, October 5

2:00 p. m.: SCIENTIFIC PROGRAM, CHEST PHYSICIANS: Ballroom, Hotel Schroeder (see p. 882)
2:00 p. m.: SCIENTIFIC PROGRAM, WISCONSIN ASSOCIATION OF ANESTHESIOLOGISTS: South Room, Hotel Schroeder (see p. 882)
2:30 p. m.: FIRST SESSION OF STATE MEDICAL SOCIETY HOUSE OF DELEGATES: East Room, Hotel Schroeder
5:30 p. m.: COURTESY BUFFET SUPPER FOR DELEGATES AND OFFICERS: Pere Marquette Room, Hotel Schroeder
6:00 p. m.: DINNER, CHEST PHYSICIANS: Club Room, Hotel Schroeder
6:00 p. m.: DINNER, INTERNATIONAL COLLEGE OF SURGEONS: Parlor G, Hotel Schroeder
6:30 p. m.: DINNER OF WISCONSIN SOCIETY OF ANESTHESIOLOGISTS: Parlor A, Hotel Schroeder

Monday, October 6

9:00 a. m.: REFERENCE COMMITTEES: In designated rooms, Fifth Floor, Hotel Schroeder
9:00 a. m.: TEACHING DEMONSTRATIONS: Milwaukee Auditorium (see p. 890)
10:15 a. m.: HOSPITAL STAFF CONFERENCES: Milwaukee Auditorium (see p. 891)
12:15 p. m.: LUNCHEONS: Hotel Schroeder (see p. 892)
2:00 p. m.: SCIENTIFIC GENERAL SESSION: Milwaukee Auditorium
5:00 p. m.: SECTION BUSINESS MEETINGS: Parlors A thru I, Hotel Schroeder
6:00 p. m.: WASHINGTON UNIVERSITY ALUMNI: University Club
6:30 p. m. SECOND SESSION OF STATE MEDICAL SOCIETY HOUSE OF DELEGATES: East Room, Hotel Schroeder
6:30 p. m.: DINNER OF WISCONSIN MEDICAL WOMEN'S SOCIETY: Matthew Keenan Health Center, 3200 N. 36th St.
8:30 p. m.: SMOKER: Ballroom, Hotel Schroeder
10:30 p. m.: INFORMAL DANCE: Ballroom, Hotel Schroeder

Tuesday, October 7

9:00 a. m.: THIRD SESSION OF STATE MEDICAL SOCIETY HOUSE OF DELEGATES: East Room, Hotel Schroeder
9:00 a. m.: TEACHING DEMONSTRATIONS: Milwaukee Auditorium (see p. 895)
10:15 a. m.: SECOND SCIENTIFIC GENERAL SESSION: Milwaukee Auditorium
12:15 p. m.: LUNCHEONS: Hotel Schroeder (see p. 897)
12:15 p. m.: MARQUETTE ALUMNI LUNCHEON: Blatz Brewery Auditorium
2:00 p. m.: THIRD SCIENTIFIC GENERAL SESSION: Milwaukee Auditorium
5:30 p. m.: PRESIDENT'S RECEPTION: East Room, Hotel Schroeder (For those attending Annual Dinner)
6:45 p. m.: ANNUAL DINNER: Ballroom, Hotel Schroeder

Wednesday, October 8

9:00 a. m.: TEACHING DEMONSTRATIONS: Milwaukee Auditorium (see p. 900)
10:15 a. m.: FOURTH SCIENTIFIC GENERAL SESSION: Milwaukee Auditorium
12:15 p. m.: LUNCHEONS: Hotel Schroeder (see p. 902)
1:00 p. m.: TEE-OFF, ANNUAL MEDICAL GOLF TOURNAMENT: Bluemound Country Club
1:30 p. m.: SECTION ON OPHTHALMOLOGY AND OTOLARYNGOLOGY: East Room, Hotel Schroeder (see p. 903)
2:00 p. m.: FINAL SCIENTIFIC MEETING: Ballroom, Hotel Schroeder
6:30 p. m.: DINNER AND AWARDS OF GOLF TOURNAMENT: Bluemound Country Club

COUNCIL ON SCIENTIFIC WORK

Members in Charge of Planning 1952 Annual Meeting Program

W. S. BUMP
Chairman

T. O. NUZUM
General Program Chairman

P. A. MIDELFART
Chairman, Scientific Exhibits

J. W. GALE
Director, 1953 Postgraduate Teaching Programs

S. A. MORTON
Director, Special Teaching Programs, 1952 Annual Meeting

R. S. BALDWIN
Medical Editor, Wisconsin Medical Journal

J. S. HIRSCHBOECK
Dean, Marquette University School of Medicine

W. S. MIDDLETON
Dean, University of Wisconsin Medical School

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Madison
Vice Speaker

COUNCILORS FOR 1952

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Frederic
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Councilor, 10th District

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Milwaukee
Councilor, 12th District

N. J. WEGMANN
Milwaukee
Councilor, 12th District

C. E. ZELLMER
Antigo
Councilor, 13th District

W. S. BUMP
Moderator, General Session

Scientific Programs for MONDAY, OCT. 6

9:00–10:00 A. M.: Small Group Teaching Programs

OBSTETRICS AND GYNECOLOGY — Stage of Exhibit Hall

TOXEMIAS OF PREGNANCY: Movie and discussion. Discussion conducted by Harold W. Shutter, M. D., Milwaukee.

FRACTURES AND APPLICATION OF CASTS—Foot of Stage

Emphasis will be placed on fractures of the radius, lower end, and fractures of the ankle. Fractures of the shaft of the humerus will also be included. Demonstrations by members of the Wisconsin Orthopedic Society, under the direction of Joseph R. Stone, M. D., Milwaukee, and James Nellen, M. D., Green Bay.

X-RAY INTERPRETATIONS—East Side of Stage

SCOUT FILM OF THE ABDOMEN: Robert W. Byrne, M. D., Milwaukee
(Those attending are invited to bring with them interesting and significant x-rays for discussion.)

MANUAL ARTIFICIAL RESPIRATION — Foot of Stage

Each day members of the Wisconsin Society of Anesthesiology will conduct demonstrations, with the use of live patients, on the newest methods of artificial respiration. Robert R. Brazy, M. D., Veterans Administration Hospital, Wood, will serve as lecturer during the course of the demonstrations. In addition, the use of the anesthetic machine and a simple oxygen tank, bag, and mask, as well as special instruments used in resuscitation by the anesthesiologist will be featured as part of the demonstration.

(THIS WILL BE REPEATED MONDAY AND TUESDAY AFTERNOON, DURING THE RECESS PERIOD, IN ADDITION TO THE DAILY MORNING DEMONSTRATIONS)

THIRD DIMENSIONAL SURGICAL FILM—Kilbourn Hall

"Mediostinal Tumor:" Surgical Dept. of George Washington University, Washington, D.C.—25 minute film, showing of which starts at 9:15 a.m. Tuesday only.

Related Teaching Exhibits

ANATOMY: Dissections and discussion on "The Anatomy of the Abdominal Cavity:" U. of W. Anatomy Dept. Doctors O. V. Hibma and Otto Mortensen as demonstrators, at foot of stage.

GROSS TISSUE: The Wisconsin Society of Pathologists will again present interesting displays and discussions on pathologic material of special significance. Located near foot of stage.

EXHIBIT DEMONSTRATIONS: Several scientific and technical exhibits will have special demonstrations of a scientific character. See official program for details.

Monday, Oct. 6

10:15–11:30 A. M.: Hospital Staff Conferences

All conferences will feature actual patients for demonstration purposes, whenever possible. These teaching conferences have become a popular feature of the Annual Meeting, and your participation through attendance is invited.

1. PEDIATRIC CONFERENCE: Staff of Children's Hospital, Milwaukee

WALKER HALL, MILWAUKEE AUDITORIUM: James P. Conway, M. D., Milwaukee, Moderator

Arthritis in Children: Vernon Kores, M. D.
Nephrosis: W. S. Polacheck, M. D.
Encephalitis: P. S. Pierson, M. D.

2. DISEASES OF THE PANCREAS: Staff of Veterans' Hospital, Wood

(Excluding diabetes mellitus, per se)

NORTH JUNEAU HALL, MILWAUKEE AUDITORIUM: Maurice Hardgrove, M. D., Milwaukee, Moderator

Physiology of the Pancreas and Laboratory Aids of Value in Diagnosis of Pancreatic Diseases: Joseph M. Lubitz, M. D.

Roentgenologic Aspects of Pancreatic Disorders: Theodore J. Pfeffer, M. D.

Acute and Chronic Pancreatitis:
Medical Aspects: Bruno J. Peters, M. D.
Surgical Aspects: C. M. Schroeder, M. D.

Tumors of the Pancreas: Forrester Raine, M. D.

3. SURGICAL–MEDICAL CONFERENCE: Staff of Milwaukee County Hospital

SOUTH KILBOURN HALL, MILWAUKEE AUDITORIUM: Joseph King, M. D., Milwaukee, Moderator

The Immediate Care of Injuries of the Hand: Frederick Bunkfeldt, M. D.
Pyelitis of Pregnancy: George S. Kilkenny, M. D.
The Treatment of Congestive Heart Failure: J. Kenneth Karr, M. D.
Late Complications of a Gunshot Wound: Joseph J. Gramling, M. D.
Carcinoma of the Lung: Joseph W. Rastetter, M. D.
X-Ray Diagnosis of Intra-abdominal Calcifications: Jerome L. Marks, M. D.

ROUND TABLE LUNCHEONS—MONDAY, OCT. 6

All Luncheons at Hotel Schroeder

FOURTH FLOOR LOCATIONS:

1. Parlor A: **Resuscitation of Patients Who Die in the Operating Room:** Claude Beck, M. D., Cleveland (Warner Bump, M. D., Rhinelander, Chairman)
2. Parlor B: **Some Aspect of Portal Hypertension:** Jacob K. Berman, M. D., Indianapolis (E. R. Schmidt, M. D., Madison, Chairman)
3. Parlor C: **Newer Drugs and Their Uses:** W. S. Middleton, M. D., Madison
4. Parlor D: **Anticoagulate Therapy: Present Status and Recent Advances:** F. W. Madison, M. D., Milwaukee
5. Parlor E: **Application of Newer Drugs in the Treatment of Hematologic Disorders:** Tibor Greenwalt, M. D., Milwaukee
6. Parlor F: **Making Hospitalization Serve Its Purpose:** Leslie Osborn, M. D., Madison
7. Parlor H: **Industrial Eye Injuries:** John Hitz, M. D., Milwaukee
8. Parlor I: **Surgical Treatment of Prostatic Hypertrophy:** J. B. Wear, M. D., Madison

FIFTH FLOOR LOCATIONS:

9. Room 507: **Selection and Training of Interns and Residents:** John Hirschboeck, M. D., Milwaukee
10. Room 508: **Diagnostic Criteria and the Surgical Results of Mitral Stenosis:** Forrester Raine, M. D., Milwaukee, and Nathan Grossman, M. D., Milwaukee
11. Pine Room: **General Prognostic Considerations of Psychotic and Neurotic Patients:** Annette C. Washburne, M. D., Madison

SPECIAL LUNCHEONS

12. East Room (Fifth Floor, immediately opposite Crystal Ballroom): **Legal Aspects of Medical Practice:** Chester C. Schneider, M. D., and Mr. Kenneth Grubb, Milwaukee. NOTE: Attendance at this will not be restricted, but advance reservations for the luncheon are required.
13. Parlor G (Fourth Floor): PAST PRESIDENT'S LUNCHEON: Open to past presidents and the incoming president of the State Society.

(USE BLANK ON PAGE 906—NAME 3 SELECTIONS, AS ATTENDANCE IS LIMITED)

NOTE: LUNCHEONS FILLED AT TIME OF PUBLICATION: 2, 3

Special Events

5:00 p. m.: ELECTION OF SECTION DELEGATES: Parlors A thru I, Hotel Schroeder

6:00 p. m.: WASHINGTON UNIVERSITY ALUMNI ASSOCIATION DINNER: University Club

6:30 p. m.: WOMEN'S MEDICAL ASSOCIATION DINNER AND PROGRAM: Matthew Keenan Health Center, 3200 N. 36th St., Milwaukee

6:30 p. m.: SECOND SESSION, HOUSE OF DELEGATES: East Room, Hotel Schroeder

8:30 p. m.: SMOKER AND PROFESSIONAL ENTERTAINMENT: Ballroom, Hotel Schroeder

10:30 p. m.: INFORMAL DANCE: Ballroom, Hotel Schroeder

Monday, Oct. 6

2:00 P.M.: General Scientific Session

JUNEAU HALL—MILWAUKEE AUDITORIUM

W. S. BUMP, M. D., Rhinelander, Moderator

BECK

OUT-OF-STATE GUEST SPEAKERS

CLAUDE S. BECK, M. D.
Professor of cardiovascular surgery, Western Reserve University, School of Medicine, Cleveland

JACOB K. BERMAN, M. D.
Associate professor of surgery, Indiana School of Medicine, Indianapolis

BERMAN

2:00 p. m.: OPERATION FOR CORONARY ARTERY DISEASE: Claude S. Beck, M. D., professor of cardiovascular surgery, Western Reserve University School of Medicine, Cleveland

(The Lucy Ann Droessel Memorial Lecture, Wisconsin Heart Association)

2:45 p. m.: ATROPHIC CIRRHOSIS: Jacob K. Berman, M. D., associate professor of surgery, Indiana School of Medicine, Indianapolis

3:15 p. m.: RECESS TO VISIT EXHIBITS
Demonstration on "Manual Artificial Respiration" to be repeated.

4:15 p. m.: PRACTICAL METHODS FOR THE DIAGNOSIS AND TREATMENT OF EMOTIONAL ILLNESS: Annette C. Washburne, M. D., professor of neuropsychiatry and preventive medicine, University of Wisconsin Medical School.

(The Theresa Lemberg Rogers Memorial Lecture)

4:35 p. m.: TREATMENT OF THYROTOXICOSIS WITH RADIOACTIVE IODINE: E. C. Albright, M. D., assistant professor of medicine, University of Wisconsin Medical School

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6:30 p. m.: HOUSE OF DELEGATES: East Room, Hotel Schroeder

8:30 p. m.: SMOKER AND PROFESSIONAL ENTERTAINMENT: Ballroom, Hotel Schroeder

10:30 p. m.: INFORMAL DANCE: Ballroom, Hotel Schroeder

PRYDE AND DAY
Unicycle and Juggling Act

Monday Nite

OCTOBER 6

Smoker PROGRAM

From 8:30–10:00 p.m., Monday, October 6 the traditional "Smoker" will be held in the Crystal Ballroom of the Hotel Schroeder. . . . Open to all members, but seating capacity limited, so plan to be there early. . . . Free beer and smokes. . . . A full evening of high class professional entertainment and music. Program selected by Mr. Ben Springer, who is an impresario supreme, and has arranged the Smoker programs for the past several years.

Music by

STEVE SWEDISH AND HIS ORCHESTRA

Acts will include singing, acrobatics and plenty of humor!

THIS IS A "STAG" AFFAIR—the ladies will be in the Empire Room during the Smoker. If your wife is an Auxiliary member she can attend the Auxiliary buffet supper while you are at the Smoker, and meet you at 10:30 for the dance.

Dance Following Smoker:

From 10:30 p.m. to midnight the Ballroom will be set up in night-club style, and all members and their wives are invited to attend an informal dance, with Steve Swedish and his orchestra furnishing the music. Waitresses will be provided so that drinks may be ordered by those who desire bar service.

Scientific Programs for

TUESDAY, OCT. 7

T. O. NUZUM
Moderator, General Session

9:00–10:00 A. M.: Small Group Teaching Programs

OBSTETRICS AND GYNECOLOGY — Stage of Exhibit Hall

MANUAL ROTATION IN THE MANAGEMENT OF OCCIPUT POSTERIOR AND OCCIPUT TRANSVERSE POSITIONS: Movie and manikin demonstration with F. J. Hofmeister, M. D., Milwaukee, as discussant.

FRACTURE DEMONSTRATION—Foot of Stage

Same basic demonstration as on Monday (see Monday program for description).

X-RAY INTERPRETATIONS—East Side of Stage

X-RAY DIAGNOSIS OF FRACTURES: Hobart Wright, M. D., Milwaukee

(Those attending are invited to bring with them interesting and significant x-rays for discussion.)

MANUAL ARTIFICIAL RESPIRATION — Foot of Stage

Same as Monday demonstrations (see Monday program for description).

THIRD DIMENSIONAL SURGICAL FILM—Kilbourn Hall

"Radical Resection for Carcinoma of the Stomach:" Samuel Marshall, M. D., Lahey Clinic, Boston—25 minute film, showing of which starts at 9:15 a.m. Monday and Wednesday.

Related Teaching Exhibits

ANATOMY: Dissections and discussion on "The Anatomy of the Abdominal Cavity:" U. of W. Anatomy Dept. Doctors O. V. Hibma and Otto Mortensen as demonstrators, at foot of stage.

GROSS TISSUE: The Wisconsin Society of Pathologists will again present interesting displays and discussions on pathologic material of special significance. Located near foot of stage.

EXHIBIT DEMONSTRATIONS: Several scientific and technical exhibits will have special demonstrations of a scientific character. See official program for details.

Tuesday, Oct. 7

10:15–11:30 A.M.: Special Symposia — INTERNAL MEDICINE OBSTETRICS AND GYNECOLOGY

"DIAGNOSIS AND THERAPY OF INFECTIOUS DISEASES"

JUNEAU HALL MILWAUKEE AUDITORIUM

EINAR DANIELS, M. D., Milwaukee, Moderator

with

HALL

WENDALL HALL, M. D.: Clinical assistant professor of medicine, University of Minnesota Medical School

BURTON A. WAISBREN, M. D.: Clinical instructor of medicine, Marquette University School of Medicine

JOHN W. BROWN, M. D.: Professor of preventive medicine and director of department of student health, University of Wisconsin Medical School

THE ACUTE BACTERIAL DISEASES; Aspects of Everyday Importance: Doctor Waisbren (Therapeutic usefulness and drawbacks of antimicrobic agents employed singly or in combination)

Discussants: Doctors Hall and Brown

CHEMOTHERAPY OF TUBERCULOSIS AND BRUCELLOSIS: Doctor Hall

Discussants: Doctors Brown and Waisbren

OTHER INFECTIOUS DISEASES ENDEMIC IN WISCONSIN: Doctor Brown (Practical significance for humans of diseases common to other animals)

Discussants: Doctors Hall and Waisbren

GENERAL DISCUSSION AND QUESTIONS FROM THE AUDIENCE

"SPECIAL PROBLEMS IN OBSTETRICS AND GYNECOLOGY"

KILBOURN HALL MILWAUKEE AUDITORIUM

F. JACKSON STODDARD, M. D., Milwaukee, Moderator

THE USE OF THE SEX HORMONE PRODUCTS IN GENERAL PRACTICE: Allan C. Barnes, M. D., professor of obstetrics and gynecology, Ohio State Medical School, Columbus

PSYCHOSOMATIC ASPECTS OF STERILITY: Sprague H. Gardiner, M. D., assistant professor of obstetrics and gynecology, Indiana University School of Medicine, Indianapolis

MANAGEMENT OF BORDERLINE PELVIC CONTRACTIONS IN OBSTETRICS: D. N. Danforth, M. D., associate professor of obstetrics and gynecology, Northwestern University School of Medicine, Chicago

ROUND TABLE LUNCHEONS—TUESDAY, OCT. 7

At Hotel Schroeder Unless Otherwise Noted

FOURTH FLOOR LOCATIONS:

1. Parlor A: **Infectious Diseases with Particular Reference to Brucellosis:** Wendall Hall, M. D., Minneapolis (John Brown, M. D., Madison, Chairman)
2. Parlor B: **Disturbances of Menstruation:** Allan Barnes, M. D., Columbus, Ohio (William Hovis, M. D., Milwaukee, Chairman)
3. Parlor C: **Diabetes Mellitus:** Bruno Peters, M. D., and William Engstrom, M. D., Milwaukee
4. Parlor D: **Choice Among the Antibiotics:** Harry Beckman, M. D., Milwaukee
5. Parlor E: **Obstetrical Anesthesia:** Sprague Gardiner, M. D., Indianapolis (L. T. Servis, M. D., Milwaukee, Chairman)
6. Parlor F: **Diagnostic and Therapeutic Application of Radioactive Iodine:** E. C. Albright, M. D., Madison
7. Parlor G: **Management of Peripheral Arterial Diseases:** James E. Conley, M. D., Milwaukee
8. Parlor H: **Management of Alcoholism:** Fritz Kant, M. D., Madison

FIFTH FLOOR LOCATIONS:

9. Room 507: **Medical Problems of Air Transportation:** A. J. Herbolsheimer, M.D., Chicago (S. E. Gavin, M. D., Fond du Lac, Chairman)
   (Open to all MDs interested in aviation medicine, including CAA Examiners)
   (As part of program O. H. Comess, M. D., Chicago, will discuss "Air Transportation of Persons")
10. Room 508: **Better Business Practices in Doctors' Offices:** Mr. J. P. Revenaugh, Professional Business Management, Chicago (R. S. Baldwin, M. D., Marshfield, Chairman)
11. Pine Room: **Problems of the Newborn:** E. T. McEnery, M. D., Chicago (J. P. Conway, M. D., Milwaukee, Chairman)
12. Pere Marquette: **Electrolyte Metabolism:** Paul R. Cannon, M. D., Chicago
    (This luncheon will be open to everyone up to 40 persons. Following the luncheon and discussion there will be a regular meeting of the Wisconsin Society of Pathologists)

SPECIAL LUNCHEON

13. Convalescent Home: SPECIAL LUNCHEON AND CLINICAL DISCUSSION ON "RHEUMATIC HEART DISEASE" (Limit 25): Ely Epstein, M. D., Chairman

(USE BLANK ON PAGE 906—NAME 3 SELECTIONS, AS ATTENDANCE IS LIMITED)

NOTE: LUNCHEONS FILLED AT TIME OF PUBLICATION: 2, 4, 10

Special Events

9:00 a. m.: THIRD MEETING OF HOUSE OF DELEGATES: East Room, Hotel Schroeder

12:00 noon: MARQUETTE ALUMNI LUNCHEON: Blatz Brewery Auditorium. Get complimentary tickets at Alumni Office, 1533 W. Wisconsin Ave.

5:30 p. m.: PRESIDENT'S RECEPTION (for those attending Annual Dinner): East Room, Hotel Schroeder

6:45 p. m.: ANNUAL DINNER: Ballroom, Hotel Schroeder

MR. C. WALTER McCARTY

NEW MEMBERS OF 50 YEAR CLUB

The Annual Meeting provides an opportunity of publicly honoring members of the State Medical Society who have completed 49 years of active practice, and become members of that select circle, the "50 Year Club." New members for 1952 are:

W. H. BAYER, Merrill
R. U. CAIRNS, River Falls
H. H. CHRISTOFFERSON, Colby
MERTON FIELD, Chippewa Falls
A. M. FORD, Roberts
C. F. HARDY, Milwaukee
A. L. KASTNER, Milwaukee
J. W. KLEINBOEHL, Mercer
H. O. McMAHON, Milwaukee
A. T. NADEAU, Marinette
A. O. OLMSTED, Green Bay
W. A. PEASE, Rio
H. W. POWERS, Milwaukee
E. W. QUICK, Milwaukee
C. A. RICHARDS, Rhinelander
E. S. SCHMIDT, Green Bay
LOUIS SCHMIT, Milwaukee
J. C. TYVAND, Whitehall
R. C. WESTHOFEN, Milwaukee
C. A. WRIGHT, Wautoma

A New Type of Dinner Program

The Annual Dinner program this year isn't going to delve into the realm of medical economics, three dimensional physics, or any stuffy philosophy. It will be a rousing talk by one of the nation's most colorful editors, and an after dinner speaker without peer. Come prepared to enjoy a refreshing talk by a dynamic man, who has chosen as his subject, the title:

JOURNALISTIC OBSTETRICS

Get in on the delivery, and we assure you that it will be an experience without any anesthesia drowsiness involved.

OUR SPEAKER:

Widely known in Hoosier newspaper circles, C. Walter McCarty, editor of the Indianapolis *News*, is a native of Washington, Indiana.

"Mickey," as he is known to his friends and acquaintances, spent his boyhood in Washington and first got the feel of printers' ink on his fingers by carrying a paper route there. Later, in high school, he wrote high school notes for the home-town paper and it was then he chose newspaper work for his profession.

When he entered Indiana University, where he became a member of the Sigma Alpha Epsilon fraternity, he majored in journalism and served as editor-in-chief of the Indiana Daily Student, the oldest campus publication in America.

After leaving the university, Mickey took a position with the Indiana bureau of the Associated Press and then, a short time later, became a member of the staff of The Indianapolis *News* with which he has been identified since 1914.

In the 38 years he has been with *The News*, he has served in almost every capacity, beginning as a police reporter and working his way up until 1926 when he was made city editor. He later was named assistant managing editor and in 1934 was made managing editor. He held the position of managing editor until July 1944, at which time he was promoted to the position of president and publisher of *The News* and its radio station, WIBC.

He served in that capacity until December 1, 1948, when the merger of the Indianapolis *News* and Indianapolis *Star* was consummated. At the present time, he is editor of *The News* and he also writes a daily column under the heading, "MICKEY McCARTY SAYS."

Besides his newspaper work, Mr. McCarty has acquired a wide reputation as toastmaster and after-dinner speaker. He has been principal speaker and master of ceremonies at a number of important functions in Indianapolis, as well as other cities in Indiana and other states.

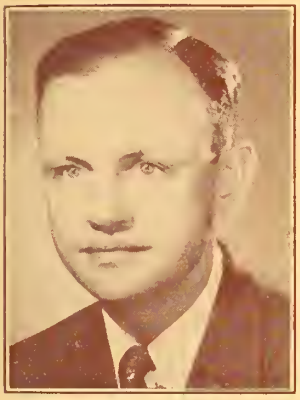
He also is a trustee of Indiana University and is vice president of the Rotary Club of Indianapolis.

Tuesday, Oct. 7

2:00 P.M.: General Scientific Session

JUNEAU HALL—MILWAUKEE AUDITORIUM

T. O. NUZUM, M. D., Janesville, Moderator



BARNES

OUT-OF-STATE GUEST SPEAKERS

ALLAN C. BARNES, M. D.
Professor and chairman of department of obstetrics and gynecology, Ohio State University College of Medicine, Columbus

PAUL R. CANNON, M. D.
Professor and chairman of department of pathology, University of Chicago

OTHERS—NO PICTURES AVAILABLE

E. T. McENERY, M. D.: Assistant clinical professor of pediatrics, Stritch School of Medicine, Loyola University, Chicago

SPRAGUE H. GARDINER, M. D.: Assistant professor of obstetrics and gynecology, Indiana University School of Medicine, Indianapolis

CANNON

2:00 p. m.: PROTEIN NEEDS IN CHILDREN (Newborn and the Pre-School Group): E. T. McEnery, M. D., assistant clinical professor of pediatrics, Stritch School of Medicine, Loyola University, Chicago

2:30 p. m.: THE DIETARY MANAGEMENT OF THE PREGNANT PATIENT: Allan C. Barnes, M. D., professor of obstetrics and gynecology, Ohio State University College of Medicine, Columbus

3:00 p. m.: RECESS TO VIEW EXHIBITS
Demonstration on "Manual Artificial Respiration" to be repeated.

3:45 p. m.: CAUSES AND TREATMENT OF THE CLINICALLY SIGNIFICANT HYPOGLYCEMIAS: W. W. Engstrom, M. D., assistant professor of medicine, Marquette University School of Medicine

4:05 p. m.: SOME PROBLEMS OF PARENTERAL ALIMENTATION: Paul R. Cannon, M. D., professor and chairman of the department of pathology, University of Chicago

4:35 p. m.: PSYCHOSOMATIC GYNECOLOGY: Sprague H. Gardiner, M. D., assistant professor of obstetrics and gynecology, Indiana University School of Medicine, Indianapolis

Dinner Speaker

C. WALTER McCARTY, Editor, Indianapolis News. Mr. McCarty is one of the most brilliant speakers of the "Fourth Estate" in the midwest, and we look forward to his address on "JOURNALISTIC OBSTETRICS."
Limited attendance, so make your reservations immediately. Use blank on page 906.

J. W. GALE
Moderator, General Session

Scientific Programs for WEDNESDAY, OCT. 8

9:00–10:00 A. M.: Small Group Teaching Programs

OBSTETRICS AND GYNECOLOGY — Stage of Exhibit Hall

ANESTHESIA AND OBSTETRICS: Showing of appropriate film and discussion led by O. Sidney Orth, M. D., professor of anesthesiology, University of Wisconsin, and William V. Luetke, M. D., Madison

FRACTURE DEMONSTRATION—Foot of Stage

Same demonstration as on Monday and Tuesday (see Monday program for description).

X-RAY INTERPRETATIONS—East Side of Stage

COMMON LESIONS OF THE SKULL AS REVEALED BY X-RAY: Lester W. Paul, M. D., Madison

(Those attending are invited to bring with them interesting and significant x-rays for discussion.)

MANUAL ARTIFICIAL RESPIRATION — Foot of Stage

Same demonstrations as on Monday and Tuesday (see Monday program for description). Demonstration will be on morning of Oct. 8 only.

Related Teaching Exhibits

ANATOMY: Dissections and discussion on "The Anatomy of the Abdominal Cavity:" U. of W. Anatomy Dept. Doctors O. V. Hibma and Otto Mortensen as demonstrators, at foot of stage.

GROSS TISSUE: The Wisconsin Society of Pathologists will again present interesting displays and discussions on pathologic material of special significance. Located near foot of stage.

EXHIBIT DEMONSTRATIONS: Several scientific and technical exhibits will have special demonstrations of a scientific character. See official program for details.

Wednesday, Oct. 8

10:15–11:30 A. M.: Special Symposia — SURGERY—PEDIATRICS RADIOLOGY

"DEVELOPMENTAL REQUIREMENTS IN CHILDHOOD"

JUNEAU HALL — MILWAUKEE AUDITORIUM

F. J. MELLENCAMP, M. D., Milwaukee, Moderator

ANDERSON

NUTRITIONAL ASPECTS OF CHILD GROWTH: John A. Anderson, M. D., professor and head of the department of pediatrics, Stanford University School of Medicine, San Francisco

SIGNIFICANT ENDOCRINE PROBLEMS IN CHILD GROWTH: Edgar S. Gordon, M. D., associate professor of medicine, University of Wisconsin Medical School

EMOTIONAL PROBLEMS OF GROWING CHILDREN: Reynold A. Jensen, M. D., associate professor of pediatrics, University of Minnesota Medical School, Minneapolis

JENSEN

"SIGNIFICANT SURGICAL PROBLEMS"

SOUTH KILBOURN HALL — MILWAUKEE AUDITORIUM

MAURICE RICE, M. D., Stevens Point, Moderator

CANCER OF THE HEAD AND NECK: Hayes Martin, M. D., assistant professor of clinical surgery, Cornell University Medical College, New York City

(By action of the Council on Scientific Work this presentation will be 1 hour in length, from 10:15–11:15 a.m.)

THE CLINICAL IMPORTANCE OF PANCREATIC FUNCTION TESTS: Robert Elman, M. D., professor of clinical surgery, Washington University School of Medicine, St. Louis, Mo.

SPECIAL PROGRAM ON RADIOLOGY

WALKER HALL — MILWAUKEE AUDITORIUM

RUSSELL WILSON, M. D., Beloit, Moderator

MYELOGRAPHY: DIAGNOSTIC ASPECTS RELATED TO THE SUBJECT: Harold O. Peterson, M. D., clinical associate professor of radiology, University of Minnesota Medical School, Minneapolis

SIGNIFICANT CASE STUDIES (10 Minutes Each)

Irradiation Studies with the Archer Lead Glass Fiber Protective Apron: T. L. Pfeffer, M. D., assistant clinical professor of radiology, Marquette University School of Medicine

The Lung in Uremia: W. L. Waskow, M. D., Madison

Evaluation of Routine Roentgen Pelvimetry: Abraham Marck, M. D., Milwaukee

A Pediatric Case Report: H. W. Hefke, M. D., associate clinical professor of radiology, Marquette University School of Medicine

ROUND TABLE LUNCHEONS—WEDNESDAY, OCT. 8

All Luncheons at Hotel Schroeder

FOURTH FLOOR LOCATIONS:

1. Parlor A: **The Choice of Medical vs. Surgical Therapy in Massive Upper Gastrointestinal Hemorrhage:** Robert Elman, M. D., St. Louis, Missouri (Joseph Gale, M. D., Madison, Chairman)
2. Parlor B: **Cancer of the Head and Neck:** Hayes Martin, M. D., New York (E. R. Schmidt, M. D., Madison, Chairman)
3. Parlor C: **Treatment of Vaginal Discharge:** Benjamin E. Urdan, M. D., Milwaukee
4. Parlor D: **Nephrosis in Children:** John Anderson, M. D., San Francisco (John Gonce, M. D., Madison, Chairman)
5. Parlor E: **Newer Drugs and Their Uses:** O. O. Meyer, M. D., Madison
6. Parlor G: **The Use of Dextran and Other Plasma Expanders in the Control of Surgical Shock:** A. R. Curreri, M. D., Madison
7. Parlor F: **Metabolic Problems in General Practice:** E. S. Gordon, M. D., Madison
8. Parlor H: **Indications and Limitations of ACTH, Cortisone, and the Antihistamine Drugs in Dermatologic Treatment:** Harry Foerster, M. D., Milwaukee
9. Parlor I: **The Treatment of Head Injuries:** David Cleveland, M. D., Milwaukee

FIFTH FLOOR LOCATIONS:

10. Room 507: **"Anxieties" as Seen in the Practice of Medicine:** Elwood Mason, M. D., Milwaukee
11. Room 508: **The Child Who Fails in School:** Reynold A. Jensen, M. D., Minneapolis (H. Kent Tenney, M. D., Madison, Chairman)
12. Committee Room: **Problems of Hypertension:** Charles Crumpton, M. D., Madison
13. Pine Room: **The Treatment of Bronchial Asthma:** Howard Lee, M. D., Milwaukee
14. Pere Marquette: **Roentgen Diagnosis of Benign Gastric Ulcers:** Harold Peterson, M. D., Minneapolis (S. A. Morton, M. D., Milwaukee, Chairman)

SPECIAL LUNCHEON AND SECTION MEETING

15. East Room (Fifth Floor, Hotel Schroeder): LUNCHEON FOR SECTION ON OPHTHALMOLOGY AND OTOLARYNGOLOGY:

[SEE NEXT PAGE FOR SECTION PROGRAM]

NOTE: LUNCHEONS FILLED AT TIME OF PUBLICATION: 1

2:00 P. M.: *Closing General Session* — CRYSTAL BALLROOM HOTEL SCHROEDER

ELMAN

J. W. GALE, M. D., Madison, Moderator

2:00 p. m.: DEGENERATIVE DISEASES OF THE HIP: Charles Ihle, M. D., Eau Claire

2:20 p. m.: ELECTROLYTE AND NUTRITIONAL BALANCE: Robert Elman, M. D., professor of clinical surgery, Washington University School of Medicine, St. Louis, Mo.

2:50 p. m.: THE PATHOGENESIS OF RHEUMATIC FEVER: John A. Anderson, M. D., professor and head of the department of pediatrics, Stanford University School of Medicine, San Francisco

(Entire program will be concluded at 3:20 p. m.)

HAAS

Section on

OPHTHALMOLOGY

and

OTOLARYNGOLOGY

HILDING

EAST ROOM—HOTEL SCHROEDER—FOLLOWING LUNCHEON

GEORGE NADEAU, M. D., Green Bay, Acting Chairman

1:00 p. m.: Business Meeting and Election of Delegate for 1953 House of Delegates

1:30 p. m.: SOME NEW POINTS IN COCHLEAR ANATOMY AND PHYSIOLOGIC IMPLICATIONS: Anderson C. Hilding, M. D., clinical professor of ophthalmology and otorhinology, University of Minnesota Medical School, Minneapolis

2:00 p. m.: THE PRESENT STATUS OF ORTHOPTICS IN OPHTHALMOLOGY: John Hitz, M. D., associate clinical professor of ophthalmology, Marquette University School of Medicine

2:20 p. m.: NEWER METHODS OF DETECTING HEARING LOSS: Charles R. Taborsky, M. D., assistant clinical professor of otolaryngology, University of Wisconsin Medical School

2:40 p. m.: TREATMENT OF SHALLOW ANGLE GLAUCOMA: Joseph S. Haas, M. D., assistant professor of ophthalmology, University of Illinois Medical School, Chicago

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OTHER WEDNESDAY OUT-OF-STATE SPEAKERS

PETERSON

MARTIN

P. A. MIDELFART

The Scientific Exhibits

Your attention is directed to the various scientific exhibits described on the following pages. These teaching exhibits have been arranged for the Council on Scientific Work by P. A. Midelfart, M. D. Each day there will be time in the morning and afternoon to study the exhibits presented.

S–8 EXAMINING THE SCHOOL CHILD

State Board of Health and Bureau of Handicapped Children, State Department of Public Instruction

Using an exhibit prepared by the American Medical Association on "The Examination of the School Child" certain modifications will be made to illustrate what is being done in this field in many Wisconsin schools. A second portion of the exhibit will illustrate the development of the hearing program conducted by the Bureau of Handicapped Children as an illustration of what can be done through cooperative efforts of lay and professional groups, with a state agency serving to coordinate the work and assisting with necessary follow up.

S–9 ETIOLOGY OF PEPTIC ULCERS AND RELATIONSHIP TO THERAPY

M. C. F. Lindert, M. D., J. J. Levin, M. D., and R. J. Mayer, M. D., Veterans Administration Center, Wood, and Marquette University School of Medicine

The etiology of peptic ulcers is unknown. The various factors involved in the etiology of peptic ulcers will be discussed. Some of the numerous and varied drugs used in the treatment of peptic ulcer will be discussed, and an attempt will be made to show the site or sites of action of the various drugs used.

S–10 DIABETES

Bruno J. Peters, M. D., Veterans Administration Center, Wood, and Marquette University School of Medicine

The exhibit deals with the problem of the placement of diabetics in industry. Precautions necessary to protect diabetics from injury are listed and discussed. Jobs contraindicated are listed together with possible complications that may arise because of the presence of diabetes; and medical department responsibilities are listed and discussed.

S–11 S–12 CARDIAC CATHETERIZATION IN CONGENITAL AND ACQUIRED HEART DISEASE

Marquette University School of Medicine and the Variety Club Heart Center

The exhibit will feature illustrations of various catheter positions and also charts illustrating impressive data obtained in various types of congenital malformations of the heart. The type of graphic recordings that are obtained in various conditions in which cardiac catheterization is important for diagnosis will also be on display.

S–13 EXPERIMENTAL STUDY OF ETIOLOGY OF ATHEROSCLEROSIS

Silas M. Evans, M. D., and Wisconsin Heart Association

It has been observed that blood from certain patients, when pulsated under physiologic conditions against a fresh human aorta obtained at autopsy, produces a change in the aortic wall similar to that seen in atherosclerosis. This phenomena will be demonstrated, together with statistical evaluation of the correlation between the clinical sources of blood and the above described experimental results, if any, to the general physician public.

S–14a GROSS TISSUE EXHIBIT

S–19a Wisconsin Society of Pathologists

The exhibit entails the showing of gross tissues and organs obtained at operation and autopsy, with demonstration of the features characteristic of the various lesions.

S–14 MILWAUKEE CANCER DIAGNOSTIC CLINIC, INC.

Operated by Marquette University School of Medicine in cooperation with the Milwaukee Division of the American Cancer Society and the Health Department of the City of Milwaukee

The exhibit is designed to show the principles of operation, which patients are eligible, the scope of the examination done, the number of patients examined since the Clinic opened on Nov. 15, 1950, and the number and types of cancers found. Various x-ray films of malignant lesions will be displayed.

S–15 TEAMWORK IN CANCER DIAGNOSIS

S–16 Wisconsin Division, American Cancer Society

The exhibit will emphasize the teamwork necessary in cancer diagnosis, the team composed of the patient, the family physician, the pathologist, the surgeon, and the radiologist. The importance of biopsy technique is stressed as well as the clinical signs of certain forms of cancer.

S–17 INFANT AND MATERNAL MORTALITY RATES

S–18 Wisconsin Academy of General Practice

The exhibit will deal with infant and maternal mortality rates during the past 20 years. These years have seen hundreds, indeed thousands, of mothers saved with the advent of antibiotics, blood banks, and careful prenatal care. Inasmuch as general practitioners deliver approximately 85 per cent of all babies born in Wisconsin, this exhibit will be a tribute to them and to the obstetricians of our state, who lead the nation by having one of the lowest infant and maternal mortality rates.

S–19 EVALUATION OF EXPERIMENTAL DRUGS IN THE TREATMENT OF ESSENTIAL HYPERTENSION

H. H. Shapiro, M.D., and C. W. Crumpton, M.D., University of Wisconsin Medical School

S–20 ELECTROENCEPHALOGRAPHY

F. J. Millen, M.D., and M. J. Primakow, M.D., Veterans Administration Center, Wood, and Marquette University School of Medicine

The exhibit will consist of cut outs of electroencephalograms with case histories attached as seen in various neurologic and psychiatric disorders; placards explaining various phases of electroencephalography; and an electroencephalograph machine to demonstrate technique.

S–21 SECTION ON RADIOLOGY

S–22

S–23

X-Ray Diagnosis of Disease of the Hip in Childhood: D. P. Babbitt, M.D., Milwaukee

Abnormal Mucosal Pattern in the Gastrointestinal Tract: O. A. Stiennon, M.D., Madison

Abdominal Aortic Angiography: Drs. T. J. Pfeffer, R. G. Zach, and Thomas Lipscomb, Milwaukee

The X-Ray Diagnosis of Diseases of the Dorsal Spine: Drs. S. A. Morton and R. W. Byrne, Milwaukee

The Postoperative Chest: Drs. C. E. Schmidt and J. D. Steele, Milwaukee

Angiocardiography: Drs. Abraham Melamed and Abraham Marck, Milwaukee

S–24 RHEUMATIC DISEASE OF HANDS: DIFFERENTIAL DIAGNOSIS

M. W. Garry, M.D., Wisconsin Rheumatism Association, Marquette University School of Medicine and Veterans Medical Center, Wood

Signs of rheumatologic involvement of the hands and fingers are common and important in practice. The differential diagnosis is occasionaly difficult, since a number of disorders may present their initial manifestation in these areas. An exhibition of the commoner rheumatic affections of the hands and fingers will be presented along with some of the diagnostic problems most frequently encountered. The display will be in the form of color transparencies with appropriate legends.

S–25 INFECTIOUS DISEASE CONTROL IN A GENERAL HOSPITAL

B. A. Waisbren, M.D., Marquette University School of Medicine and Milwaukee County Hospital

The theme of the exhibit is that service, research, and teaching are necessary for effective control of infections in a general hospital. The way to set up the tube dilution method of determining bacterial sensitivity to antibiotics will be shown. The comparative sensitivity to antibiotics of a large group of organisms isolated from patients will be demonstrated. Some research projects of the Infectious Disease Control Unit of the Milwaukee County General Hospital will also be on display.

S–26a INTRACRANIAL ANEURYSMS AND VASCULAR
S–31a ANOMALIES

H. M. Suckle, M.D., Madison

The exhibit is designed to demonstrate the general statistics, the occurrence of intracranial aneurysms and vascular anomalies, and the prognosis with treatment. The important diagnostic signs are pictured. The diagnostic method of arteriography is fully illustrated and the methods of treatment, not only with carotid ligation but also the intracranial approach, is illustrated.

S–26 ATTRITION OF THE SHOULDER

F. J. Krueger, M.D., Milwaukee

A demonstration of etiology, pathomechanics, anatomical considerations, and treatment of attritional changes in the shoulder, with particular emphasis on posture as it relates to rotator cuff and scapulocostal syndromes, will be presented.

S–27 SURGERY OF THE MANDIBLE

R. P. Gingrass, M.D., Milwaukee

This exhibit will consist of kodachrome slides and x-rays of congenital and acquired malformations and diseases of the mandible. Prognathism, ankylosis, dislocations, microgenia, pathologic fractures, cysts and tumors, etc. will be illustrated with before and after photographs and x-rays.

S–28 PLASTIC SURGERY

S–29 F. D. Bernard, M.D., University of Wisconsin Medical School

Pictoral representation of the surgical treatment of the following will be presented.

1. Congenital anomalies
2. Traumatic facial injuries
3. Burns, early and late treatment
4. Cosmetic surgery
5. Orthopedic coverage

S–30 MERTHIOLATE BONE BANK

P. L. Carnesale, M.D., P. J. Collopy, M.D., and J. O'D. McCabe, M.D., Veterans Administration Center, Wood, and Marquette University School of Medicine

The exhibit will consist of a series of serial translights including preoperative and follow-up studies illustrating the roentgenologic findings following the use of homogenous bone grafts preserved in merthiolate solution. The cases include defects of long bone, non-unions, spinal fusions, and arthrodeses of joints.

(Continued on next page)

ROUND TABLE AND DINNER RESERVATION

FILL OUT AND MAIL WITH YOUR CHECK TO STATE MEDICAL SOCIETY OF WISCONSIN, BOX 1109, MADISON

ATTENDANCE LIMITED, SO LIST ALTERNATE CHOICES OF LUNCHEONS ON DAYS YOU WILL ATTEND . . . DINNER LIMIT IS 500

[PRICE OF EACH LUNCHEON: $2.50]

I Wish to Attend One of These Luncheons in the Order Given

MONDAY, OCTOBER 6:

	Number of Luncheon	Leader
1st Choice	_____	_____
2nd Choice	_____	_____
3rd Choice	_____	_____

TUESDAY, OCTOBER 7:

	Number of Luncheon	Leader
1st Choice	_____	_____
2nd Choice	_____	_____
3rd Choice	_____	_____

WEDNESDAY, OCTOBER 8:

	Number of Luncheon	Leader
1st Choice	_____	_____
2nd Choice	_____	_____
3rd Choice	_____	_____

[Make Check Payable to "State Medical Society of Wisconsin"]

ANNUAL DINNER, TUESDAY, OCTOBER 7

Number of reservations ($4.50 per plate) _____

Signed _____
(Print Please)

Address _____

City _____

SCIENTIFIC EXHIBITS

(Continued from page 905)

S-31 MANAGEMENT OF INTRACTABLE PAIN

D. A. Cleveland, M. D., and E. J. Kiefer, M. Veterans Administration Center, Wood, a Marquette University School of Medicine

Intractable pain is that pain which is r relieved by treatment of the cause, medic physical, or psychotherapy, and which incompatible with help and comfort. Sele tive surgical therapy gives very satisfacto results in the vast majority of such cas Unilateral prefrontal lobotomy is a proc dure of choice in terminal cases or wh psychosis is a factor. Cordotomy, tractoton posterior root section, and sympathectomy, a combination of one or more of these proc dures, can be used satisfactorily in most i stances. These procedures are demonstrat in the exhibit.

S-33 COLUMBIA HOSPITAL STAFF, MILWAUKEE
S-34

The exhibit is a graphic representation certain aspects of work done by vario staff members in their respective depar ments. In some, an attempt is made to sur marize and simplify a fairly broad subjec in others a narrower field is covered in mo detail. The following subject matter will covered: "Diagnosis and Treatment of E truded Intervertebral Disc in the Cervic Region," "The Diagnosis and Treatment Trimalleolar Fractures," "'Rooming In' Pr cedures at Columbia Hospital," "Varieti of Biliary Calculi," "Differential Diagnos of Jaundice," and "Special Stains in Tissu Diagnosis."

S-35 THE ALLERGIC ASPECT OF RECURRENT VOI ITING IN INFANTS

B. B. Schoenkerman, M. D., Milwaukee

The exhibit will attempt to prove that tl majority of instances of recurrent vomitir in infancy, heretofore labeled as cause u known, is an allergic response to protein i the infant's diet. In the past a great deal formula juggling was the rule. The formul was too rich or contained too much fat. W feel that the formula is still responsibl however, the fault lies with the protei one or several of which may offend.

S-36 REGIONAL ANESTHESIA IN GENERAL PRAC TICE

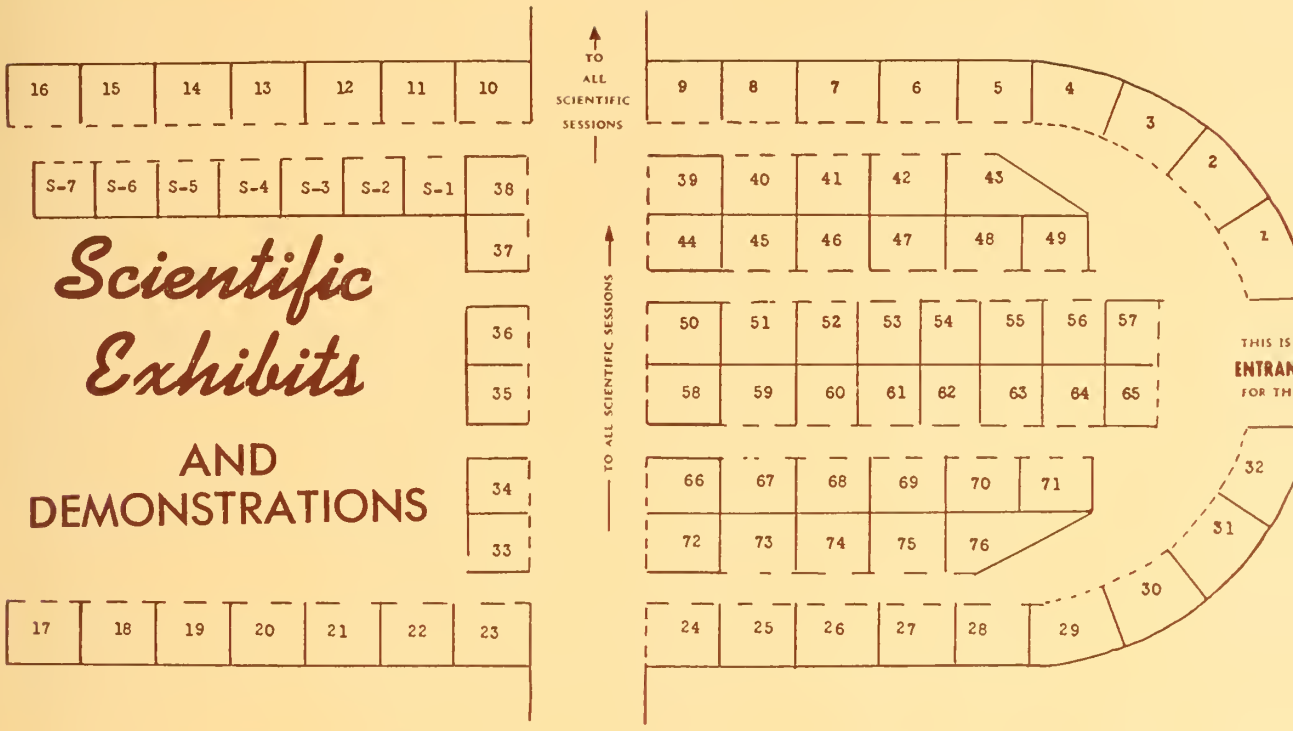
L. G. Kilpatrick, M. D., University of Wisconsi Medical School

The display will consist of a series diagrams and photographs illustrating, in step-by-step manner, the performance nerve-blocks which are likely to be of us to the general practitioner. The diagram will also illustrate the sterilization and ca of equipment, the preparation of local anes thetic solutions, and the complications local anesthesia and their treatment.

S-37 DIAGNOSIS AND THERAPY OF PULMONAR
S-38 TUBERCULOSIS

Wisconsin Anti-Tuberculosis Association

One part of the exhibit is planned t demonstrate the fact that "Any Patien May Have T.B." through the use of th chest x-ray film, tuberculin test, and sputun examination. The other portion of the exhibi is planned on "Treatment of Pulmonar Tuberculosis" by use of chemotherapy, sur gery, and sanatorium care (In cooperatio with a portion of a research program of th Wisconsin General Hospital). This exhibi will include a brief history, chest x-ra films, and pictures of gross and microscopi specimens.



TECHNICAL EXHIBITS

Booth COMPANY and PRODUCTS

37 Abbott Laboratories, North Chicago, Ill.

Abbocillin 800 M, a high-potency penicillin with 48-hour repository action; *Selsun*, an outstandingly successful new preparation for the control of common dandruff and seborrheic dermatitis; *Sulestrex*, an odorless, tasteless, pure estrone salt for oral treatment of the menopausal syndrome; *Sucaryl*, a non-caloric, heat-stable sweetening agent with no bitter after-taste; *Pentothal*, an ultra-short-acting barbiturate for intravenous use; and *Dayalets*, *Optilets*, and *Dicalets*, representing the furthest advances in the synthetic vitamin field will be on display at Booth 37.

60 A. S. Aloe Company, St. Louis, Mo.

Visit booth 60 where the Aloe representative will show you a cross section of the complete line of physician's equipment and supplies carried by the A. S. Aloe Company. Highlighted will be New Model Steeline—tomorrow's treatment room furniture today—featuring the body contour table top, magnetic door catches and advanced design, all in new decorators' colors.

17 Americana Corporation, Chicago

We cordially invite all members of the State Medical Society of Wisconsin and their guests to visit booth 17 where we will have on display, for inspection, the Mid-Century Printing of the *Encyclopedia Americana*, a supreme authority since 1829, and we will also have on display, the world famous *Book of Knowledge*, the finest reference work for children—an American tradition.

Booth COMPANY and PRODUCTS

69 American Cyanamid Company, Lederle Laboratories Division, New York

You are cordially invited to visit our exhibit in booth 69 where you will find representatives who are prepared to give you the latest information on LEDERLE products.

73 American Hospital Supply Corporation, Evanston, Ill.

The new improved Flicker Photometer for determination of toxemia in pregnancy will be on display. Dade typing serums, Sylvania Antigens and other Scientific Product's specialties will be shown. We will also show for the first time the new life-like teaching model.

68 Ames Company, Incorporated, Elkhart, Ind.

The Ames *Diagnostic Kit* will be featured. This small kit, measuring 3 by 9 inches, contains *Clinitest*—a test for urine-sugar, *Albumintest*—a test for albumin, *Acetest*—a test for acetone, and *Hematest*—a test for occult blood. No extra reagents, equipment, or accessories are needed. This kit is designed for the physician's office, small laboratory, hospital floor use, etc.

66 Ayerst, McKenna & Harrison, Ltd., New York

You are cordially invited to stop by at booth 66 to relax and discuss the Ayerst line of prescription specialties with our medical representatives. Literature and information relative to *Premarin* may be had at the booth. Representatives will be glad to discuss new developments with you.

75 Baby Development Clinic, Chicago

Baby Development Clinic presents psychological and emotional aspects of early feeding in visual as well as printed form. Ideal for use of doctors, nurses, as well as teachers, and others who are in contact with expectant parents, medical students or nurses in training.

Maternity Counselling Service . . . a courtesy service available to doctors for their maternity patients . . . relieves doctors of discussing layette needs and other preparations for home and baby.

23 The Baker Laboratories, Incorporated, Cleveland, Ohio

Baker's Modified Milk (carbohydrate added) and Varamel (no carbohydrate added) are made especially for infant feeding, from Grade A milk (U. S. Public Health Service Milk Code), which has been modified by the replacement of the milk fat with animal and vegetable oils and by the addition of vitamins and iron.

32 Barr X-Ray Company, Incorporated, Milwaukee

The Barr X-Ray Company, entering their fifteenth year of service for the members of the medical profession in Wisconsin, will have a display of Mattern X-Ray equipment and the Microtherm 'Radar' Short Wave Diathermy. We will be at booth 32, immediately to your left as you enter the exhibit hall, to greet our many friends in Wisconsin.

45 N. P. Benson Optical Company, Eau Claire

We invite you to visit our display of the newest in ophthalmic supplies and materials. We look forward to seeing you.

74 Beech-Nut Packing Company, Canajoharie, New York

S-7 House of Bidwell, Milwaukee

Complete line of orthopedic appliances.

67 Bilhuber–Knoll, Orange, New Jersey

Bilhuber–Knoll Corporation, booth 67, presents the latest developments in their medicinal chemicals and products: *Bromural*—daytime sedative, mild hypnotic; *Dilaudid*—analgesic, cough sedative; *Metrazol*—central depression, senile confusion; *Octin*—migraine, spastic disorders; *Theocalcin*—cardiotonic, diuretic; *Quadrinal*—chronic asthma; and *Valoctin*—sedo spasmolytic, dysmenorrhea.

38 The Borden Company, Chicago

Spend a few pleasant minutes with Borden's at Booth 38 and refresh your memory on our prescription products. Meet *Bremil*, conforming to the pattern of human milk; *Mull–Soy*, a liquid hypoallergenic soy food for your milk-allergic patients; *Dryco*, with its high-protein, low-fat content for formula flexibility; *Biolac*, a liquid modified milk for infant feeding; *Beta Lactose*, for carbohydrate supplementation; *Klim*, powdered whole milk; and the powdered Protein and Lactic Acid Milks for special infant feeding cases.

46 Brooks Appliance Company, Chicago

The Brooks Appliance Company will exhibit and describe in detail the technique of applying the combination pressure bandages. The moist medicated Primer plus the Elastic Adhesive Dalzoflex which are used in treating leg ulcers and phlebitis. Elastic stocking, the Nulast Elastic Crepe Bandages, and surgical instruments will also be displayed.

56, 76 Brown and Williamson Tobacco Corporation, Louisville, Ky.

The Brown and Williamson Tobacco Corporation cordially invites members of the State Medical Society of Wisconsin to visit the separate exhibits of KOOL (mildly mentholated) and VICEROY (filter-tip) cigarettes, two brands of particular interest to the medical profession. Souvenirs will be presented to members who register at the KOOL and VICEROY exhibits.

39 Burroughs Wellcome & Co., Inc., Tuckahoe, N. Y.

Featured will be *Aerosporin Otic, Solution Sterile*, which destroys gram-negative and gram-positive organisms and consists of *Aerosporin* Sulfate Polymyxin B Sulfate in propylene glycol acidified with 1 per cent acetic acid; and *Polysporin* Polymyxin B—Bacitracin Ointment, Topical and Ophthalmic, which has a broad spectrum and is effective against styes, other eye infections, pyogenic skin infections, and infections of wounds and burns.

24, 25 Camel Cigarettes, New York

Camel Cigarettes will mark your initials on an attractive plastic cigarette case filled with a package of those mild, flavorful Camels. This exhibit features a display of some of the tobaccos used in blending this famous cigarette which leads all other brands by many billions.

71 Carnation Company, Los Angeles

You are cordially invited to visit the Carnation Company booth 71, where you will see an attractive display featuring colorful translites of famous Carnation Babies. Medical representatives will explain the reasons why Carnation Milk deserves consideration as your first choice for infant feeding, child feeding, and general diet uses. Valuable literature will also be available for distribution.

58 Ciba Pharmaceutical Products, Inc., Summit, N. J.

The Ciba exhibit will feature *Apresoline*, a phthalazine derivative which is an orally effective and relatively safe therapy in hypertension of diverse etiology. Representatives in attendance will be very glad to discuss and to provide literature on this and other Ciba products.

S-6 Contour Chair Company, Milwaukee

This exhibit will consist of a display of the genuine Contour Chair–Lounges. The visitors may examine these Chairs and sit in them. We will have a representative present during the hours the hall is open who will answer all questions concerning the Chairs.

8 Downs X-Ray Company, Milwaukee

The Downs X-Ray Company of Milwaukee, distributors for H. G. Fischer and Co., x-ray and physio-therapy equipment, will show the modern, efficient, low priced Fischer Spacesaver and also the Model 400 and Model 10A Short Wave equipment.

72 C. B. Fleet Co., Inc., Lynchburg, Va.

C. B. Fleet Co., Inc., cordially invites you to stop by booth 72 to see the exhibit of *Phospho-Soda* (Fleet). *Phospho–Soda* (Fleet) is a solution containing in each hundred cubic centimeters 48 Gm. of sodium biphosphate and 18 Gm. of sodium phosphate.

1 General Electric X-Ray Company, Milwaukee

General Electric announces a *new*, improved Inductotherm. The product of complete restyling and redesigning, General Electric's new Model F Inductotherm meets every requirement for modern diathermy technics. More than handsome appearance, this scientific development offers many advanced features.

40 Gerber Products Company, Fremont, Mich.

The Gerber Baby greets physicians and their guests at the Annual Meeting of the State Medical Society of Wisconsin. Symbolizing the best in baby foods, he will continue pioneering research in the field of applied infant nutrition. His picture on "Starting" cereals, Strained and Junior foods and Gerber–Armour meats for babies is your assurance of uniform high quality.

S-4 H. J. Heinz Company, Pittsburgh, Pa.

Stop at the Heinz exhibit for these: Nutritional Data, Nutritional Observatory. Do you need Baby Gift Folders for distribution among your patients? Have you seen the additions to Heinz Baby Food line—Pre-Cooked Barley Cereal? New Junior Foods are Sweet Potatoes, Chocolate Pudding, Butterscotch Pudding, and Macaroni, Tomato Beef and Bacon.

70 Hoffman–La Roche Inc., Nutley, N. J.

Dromoran and *Gantrisin*, both Council-Accepted products, are featured at the Roche booth. *Dromoran* is a new morphine analogue, the synthesis of which is listed among the ten most important advances in science and technology in 1951. *Gantrisin* is the top-ranking sulfonamide because its higher solubility obviates renal blocking.

33, 34 Hurley X-Ray Company, Milwaukee

Your state meeting is always a pleasurable experience for our organization. Our field men will be present to visit and talk shop if you desire. Many items of interest will be on display, including Burdick FCC approved Short Wave units, Direct Writing Electrocardiographs, and Picker Accessory items. We will look forward to greeting you.

29, 30 Karrer Company, Milwaukee
4 Kremers–Urban Company, Milwaukee

Here's a hearty invitation to stop in at the K–U booth and rest a while. We'll be delighted to show you new clinical reports on the value of *Kutapressin* in the treatment of a wide range of dermatological pathologies.

S-2, 3 Laabs, Incorporated, Milwaukee

Laabs of Milwaukee, giving medical service to the doctor and his patient since 1898, presents pharmaceuticals, biologicals, chemicals, surgical instruments, and laboratory equipment.

28 Lakeside Laboratories, Inc., Milwaukee

Lakeside representatives will be on hand at the Lakeside Laboratories, Inc. booth to discuss Council–Accepted products and research in various fields.

64 Langer Laboratories, Milwaukee

Come to our booth and greet us, pals
And see our pharmaceuticals—
We have a comprehensive line;
Each price is right, each product fine
We think you'll like what we display
So come and visit, don't delay!

44 Eli Lilly and Company, Indianapolis

Your Lilly medical service representative cordially invites you to visit the Lilly exhibit located in booth 44. Featured will be a demonstration of functional packaging as an aid to medical practice. Modern manufacturing departments will be illustrated. Literature on new therapeutic developments will be available.

42 J. B. Lippincott Company, Philadelphia, Pa.

J. B. Lippincott Company presents, for your approval, a display of professional books and journals geared to the latest and most important trends in current medicine and surgery. These publications, written and edited by men active in clinical fields and teaching, are a continuation of more than 100 years of traditionally significant publishing.

21 Lov-e' Brassiere Company, Hollywood, Calif.

The Lov-é Brassiere Company will present their highly specialized line of breast supports. This company manufactures 18 separate and distinct models in a range of more than 500 sizes. All of these brassieres are custom-fitted by highly trained brassiere experts. Our representative will be glad to explain how prescription instructions are followed to meet the patient's individual requirements.

35 M & R Laboratories, Columbus, Ohio

Your *Similac* representatives are happy to take part in this meeting. They are pleased to have the opportunity to discuss with you the role of *Similac* in infant feeding. They have for you the latest Pediatric Research Conference booklets. Also available are current reprints of pediatric nutritional interest.

18 Maico of Madison, Madison

The MAICO exhibit will demonstrate the *Psychometer*, which provides for a psychogalvanomic skin response in testing the hearing of very young children (as young as three months), the malingerer, and the suspected psychogenically deafened patient. This equipment is of special interest to ENT specialists and pediatricians. Also displayed is the *Stethetron*, which is useful to all physicians for diagnosis of heart irregularities. A representative display of audiometers and hearing aids will complete the exhibit.

26 Mead Johnson and Company, Evansville, Ind.

Mead Johnson and Company, booth 26, will feature *Lactum* and *Dalactum*, convenient formulas of evaporated milk containing Dextri-Maltose; three water-soluble vitamin preparations, *Poly–Vi–Sol*, *Tri–Vi–Sol*, *Ce–Vi–Sol*, and *Fer–In–Sol*, a palatable, highly concentrated solution of ferrous sulfate. Also *Mulcin*, a pleasingly flavored vitamin emulsion, for teaspoonful dosage, as well as four *Pablum* cereals, including Barley and Rice.

19 Medco Products Company, Tulsa, Okla.

The MEDCOLATOR Stimulator, for the stimulation of innervated muscle or muscle groups ancillary to treatment by massage, is a low volt generator that will generate plenty of your interest. Electrical muscle stimulation is a valuable form of rehabilitation therapy. Be sure to visit our booth for a personal demonstration.

6 Medical Protective Company, Fort Wayne, Ind.

Having completed another year in which not a single policyholder suffered involuntary loss from his own pocket in a malpractice claim

or suit defended by this unique organization, despite large losses reported elsewhere, The Medical Protective Company, Specialists in Professional Protection Exclusively since 1899, invite your visit with its representatives at booth 6. Answers to problems in the doctor-patient relationship are yours for the asking.

54 Merck and Company, Inc., Rahway, N. J.

65 Wm. S. Merrell Company, Cincinnati, Ohio

Merrell will feature *Diothane* Ointment, a topical anesthetic that has established a reputation for positive and prolonged comfort in hemorrhoidal pain.

50 V. Mueller and Company, Chicago

V. Mueller and Company will have an extensive display of surgical instruments, including all of the new items recently featured in the Mueller Armamentarium. Our booth, number 50, is located near the center of the hall.

20 The National Drug Company, Philadelphia, Pa.

The National Drug Company, pioneer in the clinical application of resin therapy, will feature *Resion*, an intestinal absorbent; *Resinat*, a polyamine exchange resin for the treatment of peptic ulcer; and *Natrimil*, a cation exchange resin for the control of edema. Trained representatives will be in attendance to discuss our resin preparations and other specialties.

11 A. R. Nechin Company, Chicago

On exhibition and available for demonstration will be the Jones Metabolism Equipment, the CARDIOTRON (pioneer of direct-recording electrocardiographs), the Raytheon Microtherm, and the Teca Low Voltage Generators for nerve and muscle testing and stimulation. The Webster–Chicago wire recorder dictation unit, a dictation unit that combines the ultimate in operation with low initial cost and economy of operation, will also be shown.

27 John Nichols, Inc., Milwaukee

Each year's showing of the Gray Audograph Electronic Soundwriter at the State Medical Convention finds more and more enthusiastic users and prospective users of this time and money-saving dictating machine using a vinylite plastic disc (which can be used approximately 50 times). This type of equipment affords the only solution to the doctor's continual demand to conserve his time and effort.

49 Parke, Davis, and Company, Detroit

Medical service members of our staff will be in attendance at our exhibit for consultation and discussion of various products of particular interest to members of the Society. Important specialties, such as *Benadryl*, *Chloromycetin*, *Oxycel*, *Penicillin S-R*, *Thrombin Topical*, Vitamins, and others will be featured.

12 H. E. Pengelly X-Ray Company, Milwaukee

The H. E. Pengelly X-Ray Company serves as a distributor of medical x-ray equipment, both diagnostic and therapeutic. A complete line of x-ray accessories and supplies will be shown.

48 Pet Milk Company, St. Louis, Mo.

Specially trained representatives will be in attendance to discuss the use of Pet Milk in infant feeding, and to present many services that are time-savers for busy physicians. Miniature Pet Milk cans will be given to visitors at the exhibit.

31 Charles Pfizer and Company, Inc., Brooklyn, N. Y.

Terramycin, newest of the broad-spectrum antibiotics, forms a dramatic central feature of the display of Charles Pfizer and Company. The newest dosage forms of Terramycin are exhibited and indications for use are described.

3 Philip Morris and Co., Ltd., Inc., New York

Philip Morris and Company will show the results of research on the irritant effects of cigarette smoke. These results show conclusively that Philip Morris are less irritating than other cigarettes. An interesting demonstration will be made on smokers at the exhibit which will show the difference in cigarettes.

62 Physicians and Hospitals Supply Co., Inc., Minneapolis, Minn.

A complete line of up–to–date medical equipment and supplies, including such items as the Beck–Lee Cardiall, Short-Wave Diathermy apparatus, will be on display. We invite you to inspect the equipment.

16 Professional Business Service, La Crosse

Specialists in business procedure, this organization offers your office professional service designed to produce the utmost efficiency and economy in the handling of all your business affairs. Consultants will be at the booth to greet doctors and explain the services offered.

14 A. H. Robins Co., Inc., Richmond, Va.

The A. H. Robins Company exhibit features *Robalate*, N.N.R., antacid–demulcent indicated in peptic ulcer therapy and hyperacidity. The pharmaceutically elegant tablets, each containing 0.5 Gm. dihydroxy aluminum aminoacetate, are notable for exceptional palatability and smooth, non-chalky texture.

43 Roemer Drug Company, Milwaukee

The Roemer Drug Company, suppliers of surgical equipment, office furniture, hospital and laboratory supplies and drugs, has served the profession since 1898. You are cordially invited to visit us in booth 43.

13 Rystan Company, Mount Vernon, N. Y.

Rystan Company, Inc., pioneers in chlorophyll therapy, will exhibit *Chloresium* Ointment and *Chloresium* Solution (Plain), therapeutic chlorophyll preparations for the topical treatment of wounds, ulcers, burns, and dermatoses. These Council–Accepted *Chloresium* products promote the growth of healthy granulation tissue, provide relief from itching and local irritation, and deodorize malodorous lesions.

52 Sandoz Pharmaceuticals, New York

It is with a great deal of pleasure and pride that we invite you to visit our scientific exhibit at the forthcoming convention. Our representative in this area will gladly welcome you at booth 52.

57 W. B. Saunders Company, Philadelphia, Pa.

At the Saunders booth be sure to see these important new publications: Shaffer and Chapman's Correlative Cardiology; Lewis' Practical Dermatology; Bland's Clinical Use of Fluid and Electrolyte; Beckman's Pharmacology in Clinical Practice. Also Cecil's Specialties in General Practice; Cecil and Loeb's Medicine; Alvarez on the Neuroses; Lahey Clinic Surgical Practice; the Dorland Dictionary; recent numbers of the Medical and Surgical Clinics of North America; and many other books.

9 Schering Corporation, Bloomfield, N. J.

Members of the State Medical Society of Wisconsin and their guests are cordially invited to visit the Schering exhibit where new therapeutic developments will be featured. Schering representatives will be present to welcome you and to discuss with you these products of our manufacture.

10 G. D. Searle and Company, Chicago

You are cordially invited to visit the Searle booth. Featured will be *Banthine*, the true anticholinergic drug for the treatment of peptic ulcers, and *Dramamine*, for the prevention and active treatment of motion sickness. Other products of Searle Research on which information may be obtained are Searle *Aminophyllin*, *Metamucil*, and *Diodoquin*.

S-1 Sharp and Dohme, Philadelphia, Pa.

Research data relative to the potentiating effect of the antibiotics, bacitracin and tryothricin, are featured in the Sharp and Dohme booth. The synergistic effect of penicillin in conjunction with the sulfonamides and clinical data on the use of vitamin B 12 are also of major interest. Our representatives will welcome your visit.

53 Smith–Dorsey, Lincoln, Neb.

Smith–Dorsey extends to you a cordial invitation to visit their booth. Featured will be *Pabirin*, a sodium free salicylate permitting intensive therapy without excessive dosage; *Vagisol* Suppositabs, a new approach to the treatment of Trichomonas vaginitis; *Calvatine–C*, an economical vitamin and mineral supplement for prenatal therapy; *H.P.S. Sixty*, a highly palatable concentrate of natural proteins insuring a positive nitrogen balance.

5 Smith, Kline & French Laboratories, Philadelphia, Pa.

We extend a cordial invitation to you to visit our booth where we will feature one of the fundamental drugs in medicine, *Benzedrine* Sulfate N.N.R. (racemic amphetamine sulfate, S.K.F.). Our representatives will be happy to discuss this valuable central nervous stimulant and anorexigenic agent which is so highly effective in controlling appetite in the treatment of obesity.

51 E. R. Squibb and Sons, Long Island City, N. Y.

New Squibb products and new brochures of useful interest to you on products already introduced will be featured at booth 51. As in former years, your Squibb representative cordially invites you to visit the Squibb booth.

63 Ulmer Pharmacal Company, Minneapolis, Minn.

You are cordially invited to visit our booth where representatives will be ready to answer any questions regarding Ulmer specialties. We will feature Ulmer injectable line embracing estrogens, vitamins, hematinics, and other therapeutic agents.

61 The Upjohn Company, Kalamazoo, Mich.

The Upjohn display will feature Cortisone. Our new method for producing Cortisone enables a large number of patients to receive Cortisone therapy due to reduction in cost. Our representatives will be pleased to discuss Cortisone and other Upjohn products with visiting physicians.

41 U. S. Standard Products Company, Woodworth, Wis.

The U. S. Standard Products Company will have their representatives on duty to give full information on pharmaceuticals of our manufacture.

7 U. S. Vitamin Corporation, New York

22 Vaisey–Bristol Shoe Company, Inc., Rochester, N. Y.

Representatives will explain the diagnostic value of Jumping Jack shoes and the criteria for determining whether the early walking child is strengthening his foot by proper foot function or is possibly damaging it by walking poorly.

Jumping Jack shoes are not "corrective" shoes but representatives are equipped to discuss corrective wedging which may be installed in the shoes by prescription.

47 Varick Pharmacal Company, New York

Varick Pharmacal Co., Inc.—E. Fougera & Co., Inc. cordially invite physicians to discuss with professional service representatives new preparations of importance to their every day practice. Descriptive literature and samples of all products will be available.

15 Westinghouse Electric Corporation, Chicago

2 White Laboratories, Kenilworth, N. J.

Gitaligin, which has been described as "a ". . . digitalis preparation of choice," will be on display at booth 2. White's representatives will appreciate the opportunity to discuss with you the clinical background and therapeutic merit of this and other outstanding White's products.

55 C. A. Wiltrout Manufacturing Co., Milwaukee

You will find exhibited in booth 55 the latest in orthopedic appliances. We extend to you a very cordial invitation.

36 Winthrop–Stearns Incorporated, New York

Winthrop–Stearns Inc., invite you to visit booth 36, where the following products will be featured—*Telepaque*, the new, highly effective and well tolerated oral cholecystopaque medium. Gives denser, clear cut pictures of the gallbladder and, in a substantial number of cases, also permits visualization of the biliary ducts; *Neocurtasal* Iodized, trustworthy salt without sodium, with the addition of 0.01 per cent potassium iodide; *Mucilose Compound Tablets*, the new physiologic bulk laxative; *Neo-Synephrine*, time-tested, well tolerated, prolonged decongestive.

S-5 Wyeth Incorporated, Philadelphia, Pa.

You are cordially invited to visit the display of Wyeth Incorporated. This display will feature Injection *Wyamine* Sulfate, a new, effective pressor drug remarkably free from side reactions, and *Wydase*, highly purified hyaluronidase, which has proved so useful in office practice for the treatment of ankle sprains, simple fractures, hematomas, tendinitis, and bursitis.

59 Zimmer Manufacturing Company, Warsaw, Ind.

The Zimmer Manufacturing Company will exhibit in booth 59 their complete line of fracture equipment with new items to emphasize the twenty-fifth anniversary of the Company.

HOUSE OF DELEGATES--1952

HOTEL SCHROEDER—Sunday, Oct. 5, 2:30 p. m.—Monday, Oct. 6, 6:30 p. m.—Tuesday, Oct. 7, 9:00 a. m.
SPEAKER: H. Kent Tenney, M. D., Madison—VICE-SPEAKER: W. D. Stovall, M. D., Madison

Counties	Delegates	Alternates
FIRST DISTRICT		
DODGE	A. B. Kores	L. W. Schrank
JEFFERSON	C. J. Garding	F. A. Gruesen
WAUKESHA	M. J. Werra	P. E. Campbell
SECOND DISTRICT		
KENOSHA	D. N. Goldstein	L. H. Lokvam
RACINE	E. J. Schneller	L. J. Kurten
	G. J. Schulz	R. J. Schacht
WALWORTH	E. D. Sorenson	E. D. Hudson
THIRD DISTRICT		
COLUMBIA-MARQUETTE-ADAMS	J. H. Houghton	H. A. Winkler
DANE	T. A. Leonard	N. A. Hill
	A. T. Smedal	H. L. Greene
	T. W. Tormey, Jr.	R. N. Allin
	O. O. Meyer	J. A. Grab
	J. A. Hurlbut	L. E. Holmgren
	A. A. Quisling	W. A. Tanner
GREEN	M. W. Stuessy	L. G. Kindschi
ROCK	H. E. Kasten	V. S. Falk
	E. W. Reinardy	R. A. Thayer
SAUK	J. F. Moon	J. J. Rouse
FOURTH DISTRICT		
CRAWFORD	T. F. Farrell	H. E. Oppert
GRANT	K. L. Bauman	J. W. Conklin
IOWA	C. L. White	S. C. Jackson
LAFAYETTE	L. J. Unterholzner	D. J. Garland
RICHLAND	D. H. Hinke	R. E. Housner
FIFTH DISTRICT		
CALUMET	E. W. Humke	A. C. Engel
MANITOWOC	E. C. Cary	E. W. Huth
WASHINGTON-OZAUKEE	A. H. Barr	E. C. Quackenbush
SHEBOYGAN	P. B. Mason	F. A. Nause
SIXTH DISTRICT		
BROWN-KEWAUNEE-DOOR	J. W. Nellen	P. F. Dockry
	J. A. Killins	R. M. Waldkirch
FOND DU LAC	D. J. Twohig, Sr.	H. J. Kief
OUTAGAMIE	G. W. Carlson	J. E. Gmeiner
WINNEBAGO	R. H. Bitter	Vacancy
	G. R. Anderson	J. P. Canavan
SEVENTH DISTRICT		
TREMPEALEAU-JACKSON-BUFFALO	C. O. Rogne	B. C. Dockendorff
LA CROSSE	T. E. Gundersen	D. M. Buchman
MONROE	J. S. Allen	Harry Mannis
VERNON	R. S. Hirsch	T. P. Froehlke
JUNEAU	J. H. Vedner	V. M. Griffin
EIGHTH DISTRICT		
MARINETTE-FLORENCE	C. E. Koepp	K. G. Pinegar
OCONTO	R. J. Goggins	H. A. Aageson
SHAWANO	D. S. Arvold	J. W. Christofferson

Counties	Delegates	Alternates
NINTH DISTRICT		
CLARK	M. V. Overman	H. H. Christofferson
GREEN LAKE-WAUSHARA	D. P. Cupery	L. S. Shemanski
LINCOLN	R. G. Baker	K. A. Morris
MARATHON	H. R. Fehland	E. P. Ludwig
PORTAGE	A. G. Dunn	R. H. Slater
WAUPACA	A. M. Christofferson	F. J. Pfeifer
WOOD	R. E. Garrison	K. H. Doege
TENTH DISTRICT		
BARRON-WASHBURN-SAWYER-BURNETT	N. A. Eidsmoe	C. J. Strang
CHIPPEWA	W. C. Henske	J. J. Sazama
EAU CLAIRE-DUNN-PEPIN	Oscar Moland	R. J. Bryant
PIERCE-ST. CROIX	P. H. Gutzler	O. H. Epley
POLK	L. O. Simenstad	V. C. Kremser
RUSK	L. M. Lundmark	Woodruff Smith
ELEVENTH DISTRICT		
ASHLAND-BAYFIELD-IRON	J. W. Prentice	J. E. Kreher
DOUGLAS	Charles W. Giesen	H. B. Christianson
TWELFTH DISTRICT		
MILWAUKEE	J. B. Wilets	R. A. Frisch
	R. F. Purtell	C. W. Harper
	J. A. Enright	P. E. Oberbreckling
	P. J. Niland	C. F. McDonald
	W. T. Casper	A. D. Kilian
	T. J. Aylward	C. A. H. Fortier
	D. F. Pierce	L. P. Stamm
	S. A. Morton	E. A. Habeck
	J. D. Charles	H. E. Bardenwerper
	E. R. Daniels	A. J. Baumann
	F. E. Drew	E. P. Bickler
	Norbert Enzer	J. E. Conley
	J. W. Fons	J. P. Conway
	J. G. Garland	M. C. F. Lindert
	J. V. Herzog	P. J. Purtell
	S. W. Hollenbeck	L. R. Schweiger
	W. J. Houghton	Joseph Shaiken
	G. S. Kilkenny	J. M. Sullivan
THIRTEENTH DISTRICT		
FOREST	E. F. Castaldo	B. S. Rathert
LANGLADE	F. H. Garbisch	C. E. Zellmer
ONEIDA-VILAS	Marvin Wright	I. E. Schiek, Sr.
PRICE-TAYLOR	J. D. Leahy	W. W. Meyer

Sections	Delegates	Alternates
GENERAL PRACTICE	G. E. Forkin	J. A. Grab
INTERNAL MEDICINE	M. A. Hardgrove	R. N. Allin
NEUROLOGY AND PSYCHIATRY	O. C. Clark	Harry Tabachnick
OBSTETRICS AND GYNECOLOGY	M. M. Hipke	L. T. Servis
OPHTHALMOLOGY AND OTOLARYNGOLOGY	A. H. Pember	E. J. Zeiss
ORTHOPEDICS	P. J. Collopy	J. E. Miller
PATHOLOGY	W. A. D. Anderson	R. S. Haukohl
PEDIATRICS	K. B. McDonough	K. J. Winters
RADIOLOGY	W. T. Clark	H. W. Hefke
SURGERY	J. M. Sullivan	L. W. Peterson

Election of Section Delegates for 1953

Sections will meet on Monday, October 6, at 5:00 p. m. in the following rooms in the Hotel Schroeder, to elect delegates for the 1953 House of Delegates. ***(All on Fourth Floor)***

GENERAL PRACTICE: Parlor A
INTERNAL MEDICINE: Parlor B
NEUROLOGY & PSYCHIATRY: Parlor C
OBSTETRICS & GYNECOLOGY: Parlor D
PEDIATRICS: Parlor G
RADIOLOGY: Parlor H
SURGERY: Parlor I

(Section on Ophthalmology and Otolaryngology Will Elect Delegate at Section Meeting, Wednesday, October 8.)

AUXILIARY CONVENTION PROGRAM 1952

MRS. J. J. BOERSMA
Green Bay
Convention Chairman

MRS. J. M. McDONNOUGH
Chicago
Guest of Honor

Sunday, October 5

P. M.

4:00 to 6:00 Registration, Fifth Floor, Hotel Schroeder
The members of the Hospitality Committee will welcome members and guests of the Woman's Auxiliary.

6:00 Board of Directors Dinner, English Room, Hotel Schroeder
State Officers, State Chairmen, County Presidents and Presidents-Elect, and Past State Presidents

Monday, October 6

A. M.

8:00 Registration, Fifth Floor, Hotel Schroeder

9:30 Formal opening of the Twenty-Fourth Annual Meeting of the Woman's Auxiliary to the State Medical Society of Wisconsin, Pere Marquette Room, Hotel Schroeder

Mrs. R. M. Kurten, president, presiding

Invocation—Reverend Paul Schaffel, Mount Mary College, Milwaukee

Pledge to Flag—Mrs. J. S. Huebner, Fond du Lac

Pledge of Loyalty to the Woman's Auxiliary to the American Medical Association—Mrs. J. S. Huebner, Fond du Lac

Presentation of Convention Chairman, Mrs. J. J. Boersma, Green Bay

Presentation of President-Elect, Mrs. M. J. Reuter, Milwaukee

Address of Welcome — Mrs. F. O. Kuehl, Green Bay

Response—Mrs. M. J. Reuter, Milwaukee

Roll Call—Mrs. R. F. Collins, Madison

Minutes of Twenty-Third Meeting — Mrs. R. F. Collins, Madison

Convention Rules of Order — Mrs. R. E. Fitzgerald, Milwaukee

Address of the President—Mrs. R. M. Kurten, Racine

Reports of Officers

President-Elect—Mrs. M. J. Reuter

Vice-President—Mrs. R. H. Bitter

Recording Secretary—Mrs. R. F. Collins

Corresponding Secretary — Mrs. Kenneth Kehl

Treasurer—Mrs. C. R. Pearson
(Including report of Auditor)

Parliamentarian—Mrs. R. E. Fitzgerald

Reports of County Presidents of 1951–1952
(Time limit—2 minutes)

New Business

Credentials and Registration — Mrs. Fred Kuehl

P. M.

1:00 Luncheon in honor of Mrs. J. M. McDonnough, 4th Vice-President Woman's Auxiliary to the American Medical Association, Milwaukee Athletic Club
Mrs. J. J. Boersma, Convention Chairman, presiding
Fashion Parade by Muntain's of Milwaukee, Milwaukee Athletic Club
Time to shop and visit the Exhibits of the State Medical Society at the Auditorium

7:00 Buffet Supper, Empire Room, Hotel Schroeder
In honor of the Past State Presidents of the Woman's Auxiliary to the State Medical Society of Wisconsin
Mrs. E. S. Schmidt, Green Bay, presiding

10:00 Card Party, Parlors D and E, Hotel Schroeder
Dancing Party, Crystal Ballroom, Hotel Schroeder

MR. ROY MATSON

Tuesday, October 7

A. M.

8:00 Registration, Fifth Floor, Hotel Schroeder

9:30 General Session, Pere Marquette Room, Hotel Schroeder
Mrs. R. M. Kurten, president, presiding
In Memoriam
New Business
Convention Courtesy Resolutions—Mrs. R. H. Bitter
Convention Announcements—Mrs. A. L. Freedman
Report of Nominating Committee—Mrs. A. W. Hammond
Election of Officers
Installation of Officers—Mrs. J. M. McDonnough, 4th Vice-President, Woman's Auxiliary to the American Medical Association
Presentation of President's Pin—Mrs. R. M. Kurten
Inaugural Address—Mrs. M. J. Reuter
Credentials and Registration (final report)—Mrs. Fred Kuehl

11:00 Post-Convention Board Meeting, Pere Marquette Room
Mrs. M. J. Reuter, president, presiding

Workshop for County Presidents, Officers and Chairmen
Mrs. M. J. Reuter, presiding

P. M.

1:00 Luncheon, East Room, Hotel Schroeder
In honor of the County Presidents
Mrs. M. J. Reuter, president, presiding
Speaker—Mr. Roy Matson, Managing Editor of the Wisconsin State Journal, Madison
"What Europe and Africa Mean to America" (Observations of a two-month trip for selected newspaper men arranged by the Office of Defense, to evaluate the effectiveness of the Marshall Plan and our occupation of European countries)
Time to shop and visit the Exhibits of the State Medical Society at the Auditorium

5:30 Reception of the President of the State Medical Society of Wisconsin, East Room, Fifth Floor, Hotel Schroeder

6:45 Annual Dinner, State Medical Society of Wisconsin, Crystal Ballroom, Hotel Schroeder
Speaker—Mr. C. Walter McCarty, Editor, Indianapolis News, Indianapolis, Indiana

MRS. R. M. KURTEN
Racine
President

Officers and Chairmen 1951-1952

MRS. M. J. REUTER
Milwaukee
President-Elect

Officers 1951-1952

Mrs. R. M. Kurten, Racine ---------- President
Mrs. M. J. Reuter, Milwaukee ---- President-Elect
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THE MEDICAL FORUM

DOCTOR ARVESON RAPS TRUMAN HEALTH COMMISSION

Doctors: Get this Blue Shield–Blue Cross Information Dispenser now.

Doctors Urged to Tell Patients About Blue Shield–Blue Cross

Madison, Sept. 5.— Wisconsin physicians are urged to help their patients budget the costs of surgical–medical–hospital expenses.

Blue Shield and Blue Cross have announced the availability of dispensers and pamphlet literature which can be placed in the doctor's office as shown above.

These dispensers are available from the office of the State Medical Society, Box 1109, Madison, Wisconsin. There is no cost involved —the dispenser with adequate supply of pamphlets will be shipped directly to the physician.

The dispenser is an attractive white and blue plastic container. The pamphlets are colorful and easily read.

Many physicians report that patients request information about Blue Shield and Blue Cross, but, with some exceptions, most physicians have not had the materials on hand with which to supply details about how the coverage may be obtained.

The dispensers and the pamphlets will be particularly useful to provide Blue Shield–Blue Cross information to individuals and families who have no means of obtaining group coverage. The literature is aimed at the non-group subscriber.

Byron Ostby, field secretary of the state medical society, is developing a plan by which the pamphlets for the dispenser will be kept in adequate supply for everyone who uses this method of informing his patients about Blue Shield and Blue Cross.

In answer to Dr. Arveson's telegram to both candidates, *Eisenhower (on tour) replied through his personal assistant, reiterating his opposition to socialization of medicine* and stating that his research department was gathering material on which he could formulate an opinion. *Stevenson (also on tour) replied through his assistant, Wilson Wyatt—"Ten minutes per person does seem like a short time."*

Minneapolis, Sept. 2.—The State Medical Society of Wisconsin today assailed the tactics of President Truman's Commission on the Health Needs of the Nation and called on presidential candidates Adlai Stevenson and Dwight Eisenhower to state their plans for the future of the Commission if either is elected president.

The Commission held a one-day hearing at Minneapolis today to study the health needs of Iowa, Minnesota, North and South Dakota, Montana, and Wisconsin.

Dr. R. G. Arveson, Frederic, Wisconsin, chairman of the Council of the Wisconsin Medical Society, charged that the hearing pays only "lip service" to Truman's order of last December that the Commission make a "searching inquiry into the facts" and a "critical study of our total health requirements both immediate and long term."

He pointed out that the medical society was invited to outline Wisconsin's health needs only eight days before the hearing and was allowed to speak only ten minutes.

Immediately after the hearing Doctor Arveson sent telegrams to both candidates protesting the conduct of the hearing and asking for a statement from the two candidates as to "your intents on the future of the Commission if you are elected the nation's president."

Doctor Arveson argued "that a one-day hearing is not sufficient for an area involving six different states, and 11,000,000 people.

(Continued on page 916)

LIBRARY OF THE

HEALTH COMMISSION . . .

(Continued from page 915)

"The second point is that such gross inadequacy of notice represents either an ineptness on the part of the Commission administrative staff, or an ill-considered policy on the part of the Commission. So far as Wisconsin itself is concerned, I suggest that this hearing pays but lip service to the presidential order that there be 'a searching inquiry into the facts' and a 'critical study of our total health requirements, both immediate and long term.'"

Praising voluntary health insurance, he stated that voluntary coverage protects approximately half the citizens in Wisconsin today.

"Were it not for the carping criticism of various propaganda sources — including the unceasing demands of elements within the Federal Security Agency for compulsory health insurance, with the resulting effect of discrediting the voluntary plans—voluntary insurance would be much more extensive in Wisconsin today, as well as in the nation."

Doctor Arveson continued: "If we are to judge adequacy of research, of insurance, of public health units, and of the ability of people to purchase protection, in light of the needs of a decade ago, this nation—and my state with it —is moving so rapidly toward a millennium that the physicians of Wisconsin feel inspired and elated."

He pointed out that public health in Wisconsin stands at its highest peak in its history, and the cooperation of the board of health with the practicing physician and other health personnel "assures still further achievements." He praised the efforts of the University of Wisconsin Medical School and Marquette University School of Medicine.

He explained that the physicians of Wisconsin "will use their utmost energy to protect and relieve the farmer, the laborer, the white collar worker, and others within the moderate or lower income groups from being taxed to support government health programs in fields which are now adequately being developed and served by voluntary efforts. There can be no freedom of choice or initiative where unnecessary taxes are the added burden which virtually exhausts a man's resources."

Attorney General Says Not All Sheriff's Records Open to Public Inspection

Opinion Affects Problem Between Health Officers and the Press

Madison, Aug. 13.—Attorney General Vernon W. Thomson recently handed down an official opinion to the affect that newspapers have a right to examine the sheriff's docket, but enjoy no right of inspection of certain logs, criminal reports, automobile accident reports and other papers relating to law enforcement.

The opinion was sent to Dist. Atty. David L. Dancey of Waukesha County to settle a controversy between Sheriff Martin Fromm and the Waukesha Daily Freeman.

The sheriff had taken the position that reporters are entitled to examine only the jail register and that he would give reporters orally only such information as he thought newsworthy .

Thomson's opinion pointed out that the law has to make a choice between two conflicting public policies:

"On the one hand, there is the right of the public to be informed through the press of all matters concerning the administration of government and the execution of the law. This right should be respected by all public offices to the fullest extent that they can do so consistent with the proper performance of their duties.

"On the other hand, there is the right of the public to be protected against crime and to have the criminal law vigorously enforced. Long experience has shown that criminal investigation must be conducted in secrecy and both the legislature and the courts have given effect to this principle."

Thomson pointed out that the Supreme Court and the state legislature have declared that many records of public officials are not for public consumption.

Where there is no statute to the contrary, the Waukesha Police Department has a right to withhold certain records from public inspection, according to Thomson.

Gilbert Koenig, managing editor of the Waukesha Freeman, said, "We don't feel that this opinion is in the public interest." He indicated the paper would not take the opinion as a final answer.

Radio Shows Improve Public Relations

Chicago, July 11.—Radio shows designed to improve doctor-patient relationships are currently being broadcast by county medical societies in Ohio and Indiana.

The Mahoning County Medical Society of Youngstown, Ohio, is presenting a series of public service programs entitled "You and Your Doctor." The series consists of 52 programs which take up the training of the physician, the physician in relation to health organizations and agencies, and the physician in relation to his patients.

It is broadcast over WFMJ at 10:45 p.m. Sundays and over WKBM at 10:30 p.m. Fridays. All subjects are carefully screened by the president, Dr. S. R. Zoss, chairman of the Lay Education Committee, and the society's legal counsel.

The series features local physicians and lay people and helps citizens get better acquainted with their doctors.

A similar series is presented each week by the Vanderburgh County Medical Society of Evansville, Indiana. This five-minute, transcribed show is presented each Friday at 7 p.m. over WEOA.

It deals with the doctor's education, demands upon his time, and the local emergency call service.

British Doctors Get Pay Increase

Chicago, July 14.—The 20,000 doctors under Britain's socialized medicine set-up have received a pay increase, which will cost taxpapers nearly $100,000,000 between now and next March.

The raise, retroactive to the start of the socialized medical service in 1948, represents an average payment to each doctor of nearly $5,000.

Doctors at present earn $1.70 a year for every patient on their books, and they can have 4,000 patients. The average, however, is 2,300. The increase will mean about $1,500 more for each doctor every year.

Red Feather Campaign Explained; Includes Many Health Drives

Madison, Aug. 25.—October is Red Feather month. Throughout the United States this fall the united Red Feather campaigns will appeal to the public for donations to the Community Chests of America and the United Defense Fund.

The Red Feather campaigns are locally conducted and each community sets its own fund goal. Last year campaigns throughout the country raised an estimated 240 million dollars.

Among the services provided by the Community Chests are the following: Youth services—Boy Scouts, Girl Scouts, Camp Fire Girls, Boys' Clubs, Neighborhood Houses, Summer Camps, YMCA, YWCA, Settlements, etc.

Care of Children—protection, foster home care, children's institutions, day nurseries, maternity homes, vocational training for children.

Provides Many Other Services

Family Service—assistance to families, the handicapped, legal aid, transients, adult vocational and employment aid, care of aged.

Health Services—visiting nurses, clinics, mental hygiene, child guidance, institutions for convalescents or chronically ill, and hospital care.

Overall community welfare planning—community welfare councils, information centers, social service exchange and other common service.

Other services—safety leagues, special studies, interracial committees, National and State appeals, etc., except United Defense Fund.

United Defense Fund—USO and other defense services.

In many communities the appeals of national health and welfare agencies such as Red Cross, heart, cancer, polio, crippled children, tuberculosis and others join with the united campaigns in certain areas of solicitation.

The United Defense Fund was created in 1950, and has since been made a part of the Community Chest campaign. This fund provides assistance to the USO, United Community Defense Services (assistance to boom towns near military camps and defense plants); The American Social Hygiene Association (advises civil and military authorities on maintaining decent moral conditions); the National Recreation Association (works with armed forces in towns near camps on recreation programs); American Relief for Korea (clothing and blankets to destitute Koreans); and the United Seaman's Service (establishes service centers in five overseas ports).

Wisconsin to Receive Medical Supplies for Civil Defense

Madison, Aug. 6.—More than $65,000 in medical supplies and equipment has been ordered for the 100 mobile civil defense teams in Wisconsin, according to Maj. Gen. Ralph Olson, state civil defense director.

Delivery can be expected piecemeal over a period of the next 15 months, he said. As the supplies are delivered to Wisconsin they will be stored at Camp Williams. Personnel at the camp will package the supplies into units.

A limited supply of aureomycin has already been delivered to the state and is being stored under supervision of the State Board of Health with provision for rotation of supplies to prevent spoilage.

Gen. Olson also reported that state civil defense authorities have been given authority to purchase more than $127,000 of litters and litter-cots and about $100,000 of blood plasma. The plasma will be supplied by the Junior League Blood Bank of Milwaukee.

The American Medical Association's Washington office reports that over $1,500,000 in medical supplies and equipment is already stored in seven federal regional warehouses. Additional supplies costing $58,500,000 are on order and will be stored regionally as soon as they are delivered. Antibiotics make up the highest dollar-value item in these supplies.

Regional stockpiles are purchased and maintained entirely by funds appropriated by Congress, and are to be used to supplement state and local supplies in case of a disaster.

Joseph Beach Dies at Stevens Point

Helped Establish Wisconsin Plan

Stevens Point, Aug. 25.—Joseph B. Beach, secretary of the Hardware Mutuals Insurance Co., Stevens Point, died on Aug. 25 following several months illness.

Mr. Beach was one of those who played a leading role in the establishment of the Wisconsin Plan of surgical, medical and obstetrics insurance of the State Medical Society.

He attended the University of Wisconsin, and received his bachelor of laws degree at the University of Chicago. He was a veteran of World War I.

CLAIM BLANKS

A Wisconsin doctor is likely to handle more TIME claim blanks than any other company's. TIME, a leader in the accident and health insurance field, insures a large portion of the total number of persons carrying such insurance in Wisconsin.

Few doctors appreciate the great service given to their patients when these claim forms are handled promptly.

Any suggestions from you as to how our claim forms may be improved will certainly be appreciated.

* * *

The Time Insurance Company

213 WEST WISCONSIN AVENUE

Milwaukee 3, Wis.

PUBLIC RELATIONS FACTORS IN COLLECTING ACCOUNTS

This is the first of two articles condensed from an address by Stanley R. Mauck, Executive Secretary of the Columbus Academy of Medicine, presented at the Fourth Annual Medical Public Relations Conference of the American Medical Association in Los Angeles, California, December 3, 1951, and subsequently published in the BULLETIN of the Columbus Academy of Medicine, February, 1952.

For the past seventeen years I have served jointly as Executive Secretary of the Columbus Academy of Medicine and the Columbus Bureau of Medical Economics, one of the first professionally-controlled, multiple-service business bureaus for physicians in the country. Out of this experience I hold a deep conviction that the No. 1 public relations factor in bill collecting relates to the doctor's own office rather than the collection agency.

Good PR Begins at Home

Expressed in another way, we might say that good public relations—like charity—begins at home. The doctors themselves are responsible for much of the bad public relations growing out of collecting their fees.

Long delayed billing is not so prevalent as it was 25 years ago, but it remains a fundamental weakness in many offices.

In a recent county medical society bulletin a report of the Grievance Committee was given. The fourth grievance related to a complaint about an anesthesia bill for $44.50, received 8 months following service. The debtor had no knowledge of the service, and the amount seemed stupendous. Investigation by the committee cleared the doctor, but the report contains two significant comments: (1) had the surgeon advised the patient about the service of the anesthesiologist, there likely would have been no complaint; (2) careless handling of the charge, as reflected by the eight months' delay in billing, contributed to the complaint. This is another typical example of bad public relations unnecessarily incurred by poor business methods in the doctor's office.

Sporadic billing and little or no follow-up of slow accounts are other factors accounting for bad public relations. Delinquency in regular billing begets delinquency in payment. By a loose system of billing and follow-up of accounts, the doctor invites slow pay and possibly utter disregard of the obligation. A serious delinqency should *not* be charged against a patient until he has been made conscious of what is expected of him in the way of payment.

Collect Own Accounts

The pay-off in these situations, public relations–wise, comes when the patient, lulled into indifference by the doctor's unbusiness-like office procedure, suddenly learns that his old account has been turned over to a collection agency. Many times such accounts are paid promptly, but with a sullen protest that is harmful to the profession. Frequently they are complicated by complaints, as the value of professional service varies in inverse ratio to the time when it was rendered, especially if the bill has been turned over for collection.

An account should not be placed with an agency, and it is an injustice to the patient to do so, unless and until the doctor's own office is certain that it cannot be collected any other way.

Poor business procedure often backfires against the doctor in another area of neglect. It is not possible for the busy office, especially in larger cities, always to know about the indigent, the medically indigent and the confirmed hardship cases. However, too many times they are overlooked. Failure to get adequate information about the patient on the first call is often to blame. It is the responsibility of the doctor's office to determine these cases whenever possible, and handle the charge accordingly.

There is nothing more conducive to bad public relations than the reaction of the patient when bills of this character are turned over for collection to agencies which are interested only in the commission and press for payment by whatever means necessary, regardless of the circumstances in the case. Better business procedure in the doctor's own office will lessen the PR hazard in such cases.

Other Hardship Cases

There is another category of patients for whom doctor bills often present a distressing problem. I refer to the so-called "white collar" group—the clerks, stenographers, teachers and low-to-medium-salaried people.

Most of them are self-supporting and manage to make ends

Explaining Fees to Patients Creates Good Will on Bills

Chicago, July 11.—"This bill is terrible and I'm not going to pay it! How can you expect a working man like me to pay $128 for three days of care? What we need is hospitals run by the government."

Because antagonism for the medical profession as well as the hospitals arises out of such situations, the Siskiyou County Medical Society of Yreka, Calif., has created an information sheet for all private patients entering hospitals.

The sheet, titled "Your Doctor, Your Hospital and You," lists the various items for which the patient will be billed by the hospital, such as room, drugs, laboratory procedures, special diets, and treatment rooms. It also explains that fees for the patient's private doctor, the surgeon, the assistant surgeon, and the anesthetist are payable separately.

"Your doctor or the hospital management will be happy to explain any charges you do not understand or about which you desire further information," states the sheet. "If you have insurance to cover any or all of the above fees, inform the hospital management and your private physician immediately."

Copies of this sheet, which have been highly successful, are available upon request to the State Medical Society of Wisconsin, 704 E. Gorham Street, Madison.

meet by careful budgeting. However, a siege of sickness in the family or surgery often knocks them for a loop, financially. They deserve consideration when costly medical care is required.

An Unnecessary PR Hazard

These observations are not mere generalities—they are supported by facts. To get these facts, I asked the manager of our collection department to make a careful sampling of the accounts in our files. The object was to determine why accounts are referred to us for collection. This is what he found, based on 1612 accounts selected at random from our collection files:

Inadequate Handling in Doctor's Office ——— 656—41%

Delinquency due to delayed or irregular billing, incomplete data when account set up, charge not made to responsible party, misunderstood services and charges (consultation, anesthesia, x-ray, lab fees, industrial claims), no discussion re payment arrangements, extreme age of accounts, etc.

Hardship Cases ——— 353—22%

Those unable to pay due to indigency or medical indigency, illness, age, domestic problems, etc; those able to pay adjusted fees, or possibly full amount, if time or a payment plan had been offered to tide over temporary emergencies.

Dissatisfied Patients — 152—10%
With services or charge

Deadbeats ———— 148— 9%

Reasons for Delinquency Not Known — 303—18%

1612—100%

These findings speak for themselves and confirm our contention that good public relations in bill collecting begins at home.

In the first two categories we find that 63% of the accounts surveyed represent delinquencies which might have been controlled in the doctor's office. Expressed another way, and generalizing from this survey, it indicates that 63% of the medical accounts referred to collection agencies are needlessly subjected to this PR hazard. If this seems high, let's be conservative and adjust this figure to allow for error and make it 50% instead of 63%. The result still stands as a severe indictment of the way professional men handle the business side of medical practice. (to be continued next month)

DRS. HILL & DIETER

Date.....

Name.....

Address.....

Charge to.....

Vis.	Off.	Hos.	Self	Wife	Son	Dau.
		Findings				
Fluoroscopic						
Medical						
Electrocardiogram						
Medication						
C. B. C.						
Urine						
Sed. Rate						
Wass.						
Bl. Chem.						
Widal						
Stool						
Proctoscopic						
Miscellaneous						
				Total		

Return this slip to cashier's desk before leaving.

PATIENT'S CHARGE TICKET

DATE FOR NEXT APPOINTMENT

PATIENT'S CHARGE TICKET, designed for Doctors Hill and Dieter of Madison, is an excellent public relations measure that should find application in any physician's office. See story at right.

Doctors Hill–Dieter Find Charge Ticket Useful with Patients

Madison, Aug. 29.—For years Drs. N. A. Hill and D. G. Dieter, Madison, have listened to medical public relations men urge the use of itemized bills and the elimination of abracadabra in patient relationships.

Their concern over these vital public relations factors has resulted in the preparation and use of a "patient's charge ticket" illustrated above.

This charge ticket is prepared by the doctor in the presence of the patient during or immediately after each office visit or examination. The ticket has spaces for 13 of the most usual procedures and the doctor marks those performed on each visit. The doctor marks the amount charged for each of the procedures and totals the bill at the bottom.

The slip is then handed to the patient to take to the cashier's desk before he or she leaves the office. Space is provided for the date of the next appointment.

Both Doctor Hill and Doctor Dieter report that these charge slips have "practically eliminated all complaints about the cost of services."

Doctor Dieter points out that the tickets "eliminate all the mystery from a visit to the doctor and have simplified the handling of patient relationships as well as our own office procedures."

Doctor Hill adds that the charge ticket is an excellent opportunity for the patient to bring up the subject of payment of medical bills at a time when it is most opportune to discuss the matter with the physician.

PBS
PROFESSIONAL BUSINESS SERVICE
221 State Bank Building
La Crosse, Wisconsin
Consultants on Managerial and Tax Problems.
Practice limited to Medical and Dental Professions.
References furnished on request.

AMA PRESS DIRECTOR OUTLINES POLICY ON HANDLING SCIENTIFIC NEWS

Madison, Aug. 1.—Wisconsin physicians, particularly those who participated in the recent series of medical press conferences sponsored by the State Medical Society, will be interested in the article on press relations published in the July 19 issue of the American Medical Association Journal.

Written by John L. Bach, director of A.M.A. press relations, it deals with the problems raised by premature or sensational publicity of medical discoveries and new or untried drugs.

Although the article does not touch the highly important problem of what information a physician may give to the press concerning a patient's illness or injury, the article is probably one of the most comprehensive interpretive pieces ever written on the subject of medical science writing and the physician's role in assisting in the dissemination of accurate and authentic medical news.

Premature Announcements Disconcerting

In an introduction to the article, Dr. Paul L. Wermer, secretary of the A.M.A. Committee on Research, comments that "physicians often are disconcerted by premature or sensational announcements of medical discoveries appearing in the lay press long before any authoritative information on the subject is published in a reputable medical journal. . . . The enormous interest of the public in any item concerning medical progress results in thorough coverage of the scientific meeting of any large medical society by newspaper reporters free to attend such sessions."

Facts Should Be Checked

"What the reporter considers newsworthy and interesting, he prints with names, pictures and his own interpretation of the story. This is his inherent right as expressed and guaranteed in the term 'freedom of the press,'" according to Doctor Wermer.

"Nevertheless, it would seem advisable for science writers to check over the facts contained in their stories with the investigators. . . . Undue haste in publication may result in harm to both the laity and the writer's reputation for accuracy."

"The facts about American medicine and the health of the American people have to be told by those who know the facts," Mr. Bach's article says. "If the reporter cannot get the facts from you, the doctor, then your chances and the chances of the medical profession generally of getting an accurate story before the public may be lost.

"The fact might be recognized that no matter what physicians and scientists might accomplish, newspapers, magazines, radio and television are going to report on subjects currently within the realm of medicine. The choice then is not between publicity and no publicity. Rather, it is the choice between authentic news reports prepared with the active cooperation of physicians and medical societies on the one hand, and 'black market' of questionable accuracy on the other."

VA Outlines Benefits for Peacetime Vets

Madison, Aug. 12.—Peacetime veterans are entitled to hospitalization, outpatient medical and dental treatment and prosthetic service provided they were discharged under other than dishonorable conditions for disabilities incurred in line of duty of if receiving compensation for service-connected or service-aggravated disabilities.

This information was released by the VA to assist veterans whose active service did not include wartime service, as defined by the various laws covering such benefits, or did not include service since June 27, 1950, the start of the Korean campaign.

Peacetime veterans may also be entitled to domiciliary care if they meet the above eligibility requirements and are incapacitated from earning living and have no adequate means of support.

Certain retired persons who served only during peacetime may be eligible for medical benefits, but eligibility requirements are so varied that a check with the nearest VA office is advisable.

ILO Treaty May Force U. S. Into Compulsory System of Medical Care

Washington, D. C., July 1.—The International Labor Organization, meeting in Geneva, has approved a treaty on minimum standards of social security in 9 fields, including medical care and sickness benefits.

Approval came over the objections of employer delegations from many countries. A U. S. employer spokesman said employers would be against the entire treaty because of the medical care section alone.

U. S. Ratification Not Expected

A government may be listed as ratifying the treaty, if it promises to meet the requirements in 4 of the 9 fields of social security.

The medical care section stipulates that a country ratifying must provide a system of compulsory health insurance. Lacking this, it has two alternatives: (a) private, voluntary health insurance "administered by public authorities under established regulations" set by law, or (b) private, voluntary health insurance administered by insurance companies but under government "supervision." Coverage would have to average about 50% of the population.

Government sources agree that chances of U.S. ratification are very slight at this time, but there is no time limit on ratification.

The U.S. delegation voted in favor of the treaty, but a spokesman for the delegation was quoted as saying that this did not imply that the U. S. would accept the entire treaty.

The State Department and the President will decide whether to submit the treaty to the Senate for ratification. This would require a 2/3 vote and would place the U.S. under obligation to put at least 4 of the 9 programs into operation.

The U.S. delegates are Senator Murray (D., Mont.) and Assistant Secretary of Labor, Philip M. Kaiser, representing government; George P. Delaney of the American Federation of Labor, representing employes, and Charles P. McCormack, president of McCormack Tea & Spice Co., Baltimore, employer representative. They were assisted by a staff of 25 advisors.

THE WISCONSIN RURAL HEALTH CONFERENCE Executive Committee meets to plan the 1952 series of conferences. Left to right are Ervin Bruner, Madison, representing the Wisconsin Farmers Union; Dr. Allan Filek, Madison, State Board of Health; Mrs. Mary Evans, Beloit, Wisconsin Hospital Association; Dr. R. L. MacCornack, Whitehall, chairman of the conference and member of the Council on Medical Service of the State Medical Society; Miss Edith Bangham, Madison, University of Wisconsin Extension Division; Oswald Anderson, Madison, Wisconsin Farm Bureau Federation; and Dr. W. D. Stovall, Madison, Wisconsin Public Health Association. The committee is scheduling conferences at Green Bay, November 13, Madison, November 14, Eau Claire, November 18, and Wausau, November 19 to which farm and health leaders will be invited.

Propose Turning Over Federal Hospitals to Local Communities

Washington, D. C., Aug. 19.—A panel group of the *President's Commission on the Health Needs of the Nation* proposes that hospitalization for federal beneficiaries be provided locally.

The panel on *medical care of veterans* and other federal beneficiaries suggests that existing federal hospitals he turned over to communities "for nominal fees" with the federal government paying the costs of hospitalizing its cases. The panel would place responsibility for staffing and operating hospitals with the communities.

Such a procedure, the panel stated, "would eliminate competition between federal and local hospitals for scarce medical personnel, would make medical care equally available to all federal beneficiaries and would eliminate the problem of administering a large and bulky service."

The commission has taken no action on the proposal, which was presented during the two-day open session. The commission makes its final recommendations to the President in December.

The proposal was opposed by Vice Admiral Joel T. Boone, chief medical director of Veterans Administration. He said it would result in a "super-colossal" hospital operation and "spotty treatment" for veterans.

Dr. James C. Sargent, chairman of the AMA Council on National Emergency Medical Service, appearing on one of the panels, stated the AMA was opposed to unwarranted extension of medical care to dependents of service personnel. Dr. Sargent also noted the AMA was concerned over proper utilization of physicians in the armed services.

The commission was informed by Dr. Anthony J. J. Rourke, president, American Hospital Association, that because of increased volume of private patients under prepayment health plans, there has been a marked drop in the number of ward patients for the teaching services. He said if this trend continues, ". . . *some other way will have to be found for training the doctors of tomorrow.*"

AMA CHECKS ON ARMED FORCES USE OF PHYSICIANS

Chicago, July 7.—An investigation of the military assignments of physicians is being conducted by the American Medical Association in hopes of eliminating criticisms that some physicians are not being used wisely during their active duty with the Armed Forces.

Questionnaires are being distributed to all physicians discharged from service since July 1, 1951. The Council on National Emergency Medical Service, under the chairmanship of Dr. James C. Sargent, Milwaukee, will evaluate the replies.

An attempt will be made to determine the use to which doctors are being put in service, the amount of time spent by military physicians in supplying medical care to other than service personnel, and how the AMA can better serve medical personnel in uniform.

It is hoped that the studies will serve as a basis for recommendations concerning the "Doctor Draft Law" which is due to expire on July 1, 1953.

It will be necessary for the association to recommend to the Congress at that time whether such draft legislation should be extended or terminated, and, if extended, the form it should take.

Osteopathic Schools Get USPHS Cancer Grants

Washington, D. C. Aug. 1.—The United States Public Health Service has announced teaching grants totaling $562,000 to support training in cancer diagnosis and treatment.

No grants were made to Wisconsin medical schools, but grants totaling $96,000 were awarded to four osteopathic schools.

The osteopathic schools receiving grants were the College of Osteopathic Physicians and Surgeons, Los Angeles, Cal.; the Chicago College of Osteopathy, Chicago; Kansas City College of Osteopathy and Surgery, Kansas City, Mo.; and Kirksville College of Osteopathy and Surgery, Kirksville, Mo.

Unusual First Aid Chart in Great Demand Throughout State

Madison, Aug. 29.—A first aid chart showing the proper approach to treatment of common injuries and illness has been produced by the Council on Medical Service of the State Medical Society.

The chart was developed under the direction of Dr. T. D. Elbe, Thiensville, member of the Council. More than 20,000 copies were printed on the first run, and the demand already indicates that a reprinting will be necessary.

The posters are being distributed to every school in the state, in cooperation with the county superintendents of schools, and to all 4–H clubs and county homemakers' groups through the cooperation of the 4–H club and the county homemakers' division of the Home Economics Extension.

Teachers, 4–H leaders and county homemakers have received this chart with enthusiasm and find they have a hard time filling all the requests for extra copies. The charts are available at a cost of $3 per hundred through the state medical society.

Attractively presented in red, white and black, the first aid chart may find many uses among physicians who wish to distribute the chart to patients; among county medical societies in their medical service and emergency call service campaigns; in accident prevention programs, and in any program or campaign in the field of general health education.

Many industries would find the chart highly useful for their employees.

Civil Defense Book on Medical Care

Madison, August 1.—A series of special articles on "The Medical Aspects of Civil Defense" have been reproduced by the American Medical Association in booklet form.

These booklets are now available to physicians and the general public upon request. The booklet sells for 25 cents a single copy, and 20 cents per copy for orders of 100 or more.

The contents include:

1. **Civil Defense Organization and Medical and Health Services in Civil Defense, by James C. Sargent, M.D., Milwaukee.**
2. **Medical Aspects of Civil Defense in Biologic Warfare, Victor H Haas, M.D., Bethesda, Maryland.**
3. **Local Tactical Planning and Logistics in Medical Aspects of Civil Defense, Perrin H. Long, M.D., Brooklyn, New York.**
4. **Chemical Defense, Colonel John R. Wood, Medical Corps, United States Army.**
5. **Atomic Burn Injury, Everett Idris Evans, M.D., Richmond, Virginia.**
6. **Radiological Aspects of Civil Defense, George M. Lyon, M.D., Washington, D. C.**
7. **Atomic Bomb Injury: Radiation, Charles L. Dunham, M.D.; Eugene P. Cronkite, M.D.; George V. Le Roy, M.D., and Shields Warren, M.D., Washington, D. C.**
8. **Nature of Air Raid Casualties, Crotez F. Enloe, Jr., M. D., New York.**
9. **Mental Health and Civil Defense, Ozro T. Woods, M. D., Dallas, Texas.**
10. **Atomic Bomb Injury: Mechanical Injuries, Fiorindo A. Simeone, M.D., Cleveland, Ohio.**

Booklets may be ordered through the State Medical Society of Wisconsin, 704 East Gorham Street, Madison, Wisconsin. Please enclose coin or check.

The Only Way to Have Government by the People
Is to Have
Voting by the People!

. . . . THE PRESIDENT'S PAGE . . . .

What Does the Medical Society Do For You?

WHEN dues are raised or when they come due, each member wonders what the Medical Society does with its money and particularly what the Society does for him.

What anyone gets out of the Medical Society, like almost everything else in life, depends largely on what he puts into it. Those who are actively engaged in county and State Society work are benefited most, but only because their interest acquaints them with the wide scope of the societies' activities, and they learn how and where to seek assistance and information.

If we do not read the scientific articles in the Journal, fail to attend the Annual Meeting and the postgraduate and industrial clinics which are brought to our very doors, and neglect to take advantage of the assistance offered in securing speakers for our county and district meetings, all the efforts of our scientific committees and assistant secretary Roy Ragatz to keep us well informed medically are wasted.

Are you familiar with the Wisconsin Blue Book? It is a valuable store house of knowledge on subjects related to medical practice. Public health and narcotic regulations, licensure, autopsy rules, medical testimony, Workmen's Compensation, division of fees, tax laws, and regulations concerning group practice are only a few of the many subjects covered. Each year the January issue of the Wisconsin Medical Journal is published as a supplement to and to bring up to date the Blue Book. An hour spent in perusing the Blue Book will familiarize you with its contents, so that when a situation arises requiring information on the subjects covered, you will know where to find it. Secretary Crownhart and legal counsel Robert Murphy are willing and anxious to give you further advice on the legal aspects of medical practice.

Our Veterans Medical Service Agency has done a stupendous job in streamlining the report blanks and simplifying the entire procedure involved in the home care of Wisconsin veterans, to the satisfaction of the Veterans Administration, the veterans, and the doctors. Only those physicians who rendered such care during and after the first World War can appreciate the difference. Tom Doran and his staff handle hundreds of individual questions on specific cases in a single month.

The State Society's placement bureau is constantly helping physicians find locum tenens and assistants. It aids communities in their search for doctors. It assists graduate and incoming physicians in finding locations.

The Provident Life and Accident Insurance Plan has made it possible for all of our members to secure, as a group, better health and accident protection and at less cost than they could obtain it as individuals. It has also made it possible for those who are ineligible for individual policies to secure protection under the group policy.

The Grievance Committee is clearing up cases of misunderstanding between patients and their physicians. Some of these cases, if not so handled, would result in malpractice suits, with an aftermath of adverse publicity and an epidemic of similar suits in the community. The existence of this committee gives the public a sense of security against exorbitant charges and unfair treatment, and is one of the most effective organizations we have for good public relations.

Our new roving secretary Byron Ostby will make it possible for individual physicians and county societies to have a more direct contact with the State Society and its staff in Madison. You will be able to tell him, when he is in your neighborhood, your ideas of how the State Society can be of even greater help to you and the public. He will direct the training courses for your office help which I believe will be one of our most effective programs to make medical practice easier and more efficient.

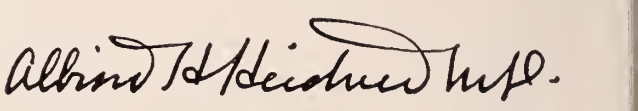
Our staff and legislative committee are not a pressure group but a source of help and information to the members of the Legislature. Their advice is sought by legislators, and the assistance they have given has been a valuable and effective force in protecting the public and the profession against ill-advised and harmful health legislation.

Various state committees are holding conferences with leaders of the legal, dental, and pharmaceutical professions. Our press-radio conferences, directed by Earl Thayer, have been enthusiastically received. Our Rural Health Conferences are participated in by the leaders of farm groups. In October the first conference of Physicians and Schools will be held. Physicians are in constant contact with men in all of these groups. By developing a more intimate knowledge of each other's problems, many of the irritations and misunderstandings which occasionally develop can be avoided. After the spade work has been done on the state level, local contacts through the county societies will be essential to make the efforts most effective.

Our insurance programs, under the direction of the Commission on Prepaid Plans, are developing and expanding at a tremendous rate. It is the most effective answer we have for socialized medicine. Wisconsin Physicians Service, Surgical Care of Milwaukee, and the Wisconsin Plan now cover nearly 800,000 persons. When we add this number to those covered under similar plans operated by private insurance companies, we find about one-third of our population having protection against costs of surgical and medical care. Our plans are being developed with adequate administrative and statistical personnel to make them efficient and safe. Ralph Weber, Marion Christensen, Ray Hoops, and Ray Koenig are doing fine work in this department. Dr. E. M. Dessloch, who heads the Commission, is doing a splendid job at a great personal sacrifice. I wish to commend and thank him personally and in the name of the doctors of Wisconsin.

I have merely skimmed the surface in this enumeration of some of the many services our State Society is giving to its members and the state as a whole.

After a year of intimate contact with our staff, I can confidently say that in my opinion it ranks at or very near the top in comparison with any similar group in this country. Every person is well trained and particularly competent to perform the duties assigned to him or her. Under the able leadership of Charles Crownhart, this staff has developed an enthusiasm and loyalty to medicine which stimulates it to work far beyond the usual call of duty. All of its members give up most of their weekends and spend many of their nights traveling to and from distant parts of the state. It has been a great privilege for me to work with them, in your behalf, during the past year.



Minutes of the Council Meeting, Madison May 17-18, 1952

1. Call to Order

The Council was called to order by Chairman Arveson at 2:30 p.m., Saturday, May 17, 1952, in the office of the State Medical Society, Madison.

2. Roll Call

Councilors present were Doctors Costello, Hemmingsen, Tenney, Kasten, Dessloch, Heidner, McCarey, Fox, Bell, Kidder, Arveson, Galasinski, Bernhart, Wegmann (Saturday), and Zellmer.

Also present were President-Elect Griffith; Drs. S. E. Gavin, W. D. Stovall, and D. H. Witte, delegates to the American Medical Association; Dr. Gunnar Gundersen, trustee of the American Medical Association; Dr. F. L. Weston, treasurer; Dr. J. S. Supernaw, chairman, Veterans Medical Service Agency; Dr. R. E. Fitzgerald, chairman of the Committee on Grievances; Drs. Olson, Cornwall, and Gutzler of River Falls (Saturday); Drs. E. D. Schwade and Mabel Masten (Sunday).

Others present were Secretary Crownhart; Assistant Secretary Ragatz; Mr. T. J. Doran, claims director; Mr. R. B. Murphy and Mr. S. E. Gavin, legal counsel; Mr. E. R. Thayer, director of public information; Mr. B. C. Ostby, field secretary; Mr. W. C. White, consulting actuary; Miss Leona Kellerman and Miss Joan Pyre.

3. Wisconsin Diabetes Association

Dr. Karl H. Beck, secretary-treasurer of the Wisconsin Diabetes Association, had filed with the State Medical Society the by-laws of the association, which had tentative approval of the American Diabetes Association pending a statement from the State Medical Society of Wisconsin to the effect that it affirms that the organization will have state-wide representation.

On motion of Doctors Fox-Bell, carried, the Council recognized the Wisconsin Diabetes Association as a state-wide organization.

4. Auxiliary and Nurse Recruitment Program

The Auxiliary has undertaken a nurse recruitment program in cooperation with the State Department of Nurses, and requested an appropriation of $250 to assist in defraying the expense of compiling ringbooks containing bulletins and pertinent information from accredited practical and professional nurses training schools in the state for distribution to high school superintendents as a vocational guide. The Audit and Budget Committee recommended the appropriation.

On motion of Doctors McCarey-Dessloch, carried, the Council approved the appropriation of $250 to assist in this project.

5. Survey of Nursing Education

The State Board of Nursing, concerned with the lack of qualified nurses, proposes to initiate a thorough study of nursing education in Wisconsin through an Advisory Committee having representation from the following organizations: Wisconsin Hospital Association, Wisconsin Conference of Catholic Hospitals, State Medical Society of Wisconsin, Wisconsin League of Nursing Education, Wisconsin State Nurses' Association, Wisconsin State Organization of Public Health Nursing, Wisconsin State Board of Nursing, and three representing the consumers of nursing, and two representing general education.

The State Medical Society was requested to nominate three physicians associated full time with a school of medicine, and three physicians in private practice. The State Board of Nursing would appoint one physician in each category to serve on the 17 member Advisory Committee.

On motion of Doctors Dessloch-Costello, carried, the Council authorized the submission of nominees to the State Board of Nursing.

6. American Medical Association Meeting, June 9-13, 1952

The delegates to the American Medical Association were present to discuss matters expected to come before the House of Delegates.

A. *Veterans Administration*—Policy in connection with care of veteran with nonservice-connected disability.

The American Association of Medical Colleges has expressed its opposition to the use of Veterans Administration facilities for veterans with nonservice-connected illnesses and disabilities who are, by any reasonable definition, able to pay for adequate medical care. The Tennessee State Medical Association has passed a resolution supporting that attitude.

The Association of American Physicians and Surgeons has adopted a resolution to amend the Veteran's Administration Act to provide for the treatment and care of veterans with service-connected disabilities only, and directs attention to the practice of some Veterans Hospitals of accepting insurance payments from veterans with nonservice-connected disabilities and who carry some form of medical or hospitalization insurance.

The Medical Society of the State of North Carolina adopted a resolution calling for the admission of only "charity nondisability cases properly certified by local welfare agencies."

The Arkansas Medical Society opposes the present policy of the Veterans Administration of accepting hospital and other benefits from insurance companies on the grounds that such practice places government controlled and subsidized hospital and doctors in competition with local hospital and medical facilities.

The Veterans Medical Service Agency Committee, in a recent meeting, supported the substance of these criticisms, and recommended that the Council record itself in similar fashion.

On motion of Doctors Kasten–Kidder, carried, the Council approved the recommendation of the Veterans Medical Service Agency Committee.

B. *Self-Employed Physicians.*

It was noted that at the present time self-employed physicians are not under provisions for old-age disability benefits. The American Medical Association has been of the opinion that physicians contribute all of their professional lives, but that if they earn more than $50 when they reach the eligible age, they could not draw on the benefits of old-age security. Therefore, there was little practical reason for such individuals as physicians, dentists, lawyers, and others of that status to be covered by Social Security.

There seemed every reason to believe that the federal government wanted the inclusion of the professions primarily to provide them with more tax money.

The AMA about a year ago, acting on a resolution that came through the Council and approved by the House of Delegates of the AMA, together with others of the same character, acted to support a bill in Congress to permit physicians in groups, individually, through their state medical societies as well as lawyers and others to establish retirement plans and to have the cost of those plans within certain formula a tax deduction as a business expense.

The AMA advised that the Keogh–Reed bill was being heard in a committee of which Congressman John Byrnes of Wisconsin is chairman.

It was suggested that the Council authorize the secretary to direct to Congressman Byrnes a message supporting the bill, and the suggestion that expert testimony could be made available to the committee in support of the bill by Mr. Robert Murphy, legal counsel of the Society.

It was moved by Doctors Dessloch–McCarey, carried, that the secretary be so instructed, and that the AMA delegates be asked to give their support to such a measure in discussions before the AMA House of Delegates.

C. *Proposals to Certify Non-M.D. Microbiologists.*

The American Board of Pathology was considering giving support to the formation of an American Board of Medical Microbiology, which would include bacteriology, serology, and parasitology.

The American Board of Pathology proposed to discontinue issuance of certificates in these fields, but would continue to certify in the field of clinical pathology, and in all phases of pathologic anatomy. The American Board of Pathology and the proposed American Board of Medical Microbiology would be independent, but each would have representation from the other, and the new board would certify non-M.D. microbiologists.

The Advisory Board for Medical Specialties approved the proposal and the matter will be put in the hands of the AMA Council on Medical Education and Hospitals, which must approve a new board before it is recognized as an official organization by the American Medical Association.

Formal application had been withheld, pending completion of proposed requirements for residency training. There is no formal expression with reference to the proposal by the College of American Pathologists, although it was apparent that the group was disturbed over impending developments.

The Marinette County Medical Society had adopted a resolution in opposition to the formation of this group, as had the Wisconsin Society of Pathologists.

It was moved by Doctors Bell–Dessloch, carried, that it was the opinion of the Council that there was no objection to the formation of a group of non-medical microbiologists, but that sponsorship, approval, and certification should be only to medical graduates, physicians trained in the field of medical practice.

C. *Social Security Measure.*

Dr. W. H. Huron of Michigan telephoned a message that the Legislative Committee of the American Medical Association wished the Medical Society to take a position against Bill H. R. 7800, Section 3. In general, the bill related to expansion of benefits under Social Security, particularly payments made under the provisions for temporary and permanent disability. The bill was reported out of committee on Friday without recommendations, but its proponents in the Social Security Administration were anxious to speed its passage, and action might be taken the first of next week.

Section 3 provided that the Federal Social Security Administrator establish regulations to require periodic physical examinations and reports for those eligible for temporary and permanent disability benefits. This section permitted the Social Security administrator to specify certain physicians to make these examinations. He might, for example, designate a panel in every major city to be known as the government physicians for examination purposes. He would have the power to set the fees for the examination and reports. The AMA felt that this would set a highly dangerous precedent in the field of the administration of medical aspects of the Social Security programs and pave the way for quick, full control of the profession in event the administration chose to do so.

Doctor Huron asked that telegrams or other immediate contacts be made with the senators.

No action was taken by the Council.

D. *National Doctors Committee for Improved Federal Medical Services and S. 1140 Relating to a New Department of Health.*

The American Medical Association has long endorsed a proposal for a Department of Health under which, in general, federal health services would be combined. It has *not* supported the inclusion of the

medical facilities of the Armed Services and of the Veterans Administration in the new department on the basis that to do so might seriously hamper the primary mission of these activities.

The National Doctors Committee is an affiliate of the Citizens Committee for the Hoover Report and has membership from each of the specialties, as well as general practitioners. It urges each state medical society to endorse the basic programs designed to effectuate completely a Federal Department of Health. The American Medical Association has been in conference with the National Committee, but holds that the present activity of that group "is another attempt to confuse and divide the profession with respect to legislative recommendations for consolidation of health services."

On motion of Doctors Kasten–Bernhart, carried, the Council supported the position of the American Medical Association with regard to creation of a Federal Department of Health.

7. Wisconsin Pharmaceutical Association

On May 8, 1952, all physicians received a letter addressed by Mr. Jennings Murphy, secretary of the Wisconsin Pharmaceutical Association, explaining the Association's action to secure an interpretation of the Dangerous Drug Law.

In reply, the Interim Committee recommended to the Council for approval, a letter to Wisconsin doctors and pharmacists.

On motion of Doctors McCarey–Kidder, the Council approved the distribution of the letter to doctors and pharmacists.

8. State Historical Society

Mr. Clifford Lord, director of the State Historical Society, had extended an invitation to councilors, officers, and invited guests to visit the Society for the purpose of viewing an exhibit specially developed for the occasion, demonstrating work and activities in medical history. Therefore, the meeting recessed at 5.30 p.m. and those present visited the Historical Society for this purpose.

9. Matters of General Interest to Profession

On Sunday morning, when the Council reconvened, Doctor Arveson suggested the advisability of including time on the agenda of future meetings for a discussion of problems and matters of general interest to the profession. At this time, councilors could bring in the thoughts of those whom they represent for a general discussion of problems of medical practice.

10. Meeting with State Board of Medical Examiners

It was noted that the State Board of Medical Examiners was unable to accept the invitation of the Council to meet with it on Saturday. The Board, however, extended an invitation to the Council to meet with it in Milwaukee at its regular July meeting. The Council meeting scheduled for July would be held in another section of the state, and it would thus be difficult for the entire Council to join with the Board in Milwaukee and hold two meetings in the month of July.

The Interim Committee therefore recommended that the Committee on Public Policy, if possible, meet with the State Board of Medical Examiners at its July meeting, for a discussion of the Medical Practice Act.

On motion of Doctors Fox–Kidder, carried, the Council instructed the secretary to extend an invitation to the Board of Medical Examiners to be guests of the Committee on Public Policy at a meeting at the Milwaukee Athletic Club or University Club, on some occasion when the Board is convened in Milwaukee for its July session. The motion was not carried unanimously.

11. Report of the Commission on Prepaid Plans

Doctor Dessloch, chairman of the Commission, presented the following report of the Commission:

In its November 1951 meeting, the Council of the State Medical Society directed the organization of the Commission on Prepaid Plans, specified its function, determined its structure, and asked that it report quarterly to the Council.

The Commission was promply organized, has held meetings December 15 and 16, 1951, and March 2, 1952, and its third meeting is scheduled for June 15 and 16. By the time of its June meeting, all of the committees of the Commission will have held at least one session. The Executive Committee met on March 1, again on March 19, and on April 23. The Committee on Physician and Public Relations held its first meeting on March 1, and has filed with the Commission a comprehensive report which still involves a considerable amount of action.

The Claims Committee has been, by necessity, one of those holding frequent meetings. Since the organization of the Commission, the Claims Committee has held five formal meetings, and is, at the present time, planning a regular monthly meeting.

Both the Committee on Enrollment and Underwriting and the Blue Cross Committee have held meetings with matters of considerable detail before them.

Specifications were adopted by the Commission at its December 1951 meeting which thoroughly detail the principal content of contracts of Blue Shield of Wisconsin, as well as of the Wisconsin Plan.

(1) The standard group contract, (2) the non-group contract, sold to individuals, and (3) the conversion contract, available to those who leave a group and who do not affiliate with another group through which they can be billed, have been completed and are in the process of distribution.

The rate structure for all current contracts has been developed by the actuaries, and approved through the mechanisms of the Commission. In the sale of contracts to groups, rates will vary between sizes of groups, as well as between the character of groups. As an example of the latter, a group contract is made available to associations in which the members individually pay the premium rate. This is not a group comparable to one in which all members are employed by a common employer, and payroll deductions are made which facilitate

the payment of the rate, and reduce administrative costs in collection. It is for such reason that a variation in rates has been developed.

At its December 1951 meeting, with representatives of participating companies in the Wisconsin Plan present, as well as staff representation from Blue Cross, the time table was established for availability of the contract on April 1, with all sales of the old contract to be discontinued after July 1, 1952. It was hoped that with but some minor exceptions, the old contracts of both Wisconsin Plan and Wisconsin Physicians Service could be eliminated entirely by July 1, 1953.

One of the controversial issues concerning the Wisconsin Plan has been that administration of certain of its problems, primarily performed in the interest of participating physicians or patients, has been carried at the expense of the Society to an amount estimated at approximaely $5,000 annually.

The Commission has acted, with insurance carriers acceptance, to secure reimbursement of these costs by those companies who in the future participate in the program. All companies now participating have been billed $500 to cover the period of April 1, 1952 to June 30, 1953, and the staff has established a cost accounting method so that in annual billing, beginning on July 1, 1953, either the deficit or surplus in the amounts received can be reflected for the ensuing year. As of the date of the preparation of this report, three insurance companies have remitted the amount billed, and a number of others have indicated that they would do so in the ordinary course of their particular routines.

As of May 15, two participating companies have submitted their policy for study and approval, and others are expected to do so in the near future. All policies are very carefully reviewed as to the most minute detail to make certain that there is complete compliance with the specifications governing both programs.

Four companies have withdrawn from participation, and it is expected that several others will do likewise.

Because of the change in the full payment levels, and the substantial revisions in the substance of Wisconsin Physicians Service and the Wisconsin Plan, it was felt necessary that all physicians in Wisconsin be asked to sign as new participants in the program. Two mailings have been directed to every member of the Society, and the option has been provided those solicited to participate in either one or both of the plans, as they see fit.

As of May 6, more than 1,600 physicians had indicated their desire to participate, and of the total number, approximately 25 have declined participation in one or the other plan, most of them not desiring to participate in the Wisconsin Plan.

Because of increased volume of activity and anticipated administrative problems arising out of the fact that during the next year claims will relate to not only the two new schedules, but to the old schedule as well, administrative problems have become increasingly complex. Every effort is being made to simplify their handling, and to establish mechanisms which should suffice for years to come.

The payment of claims direct to physicians by Blue Shield of Wisconsin will be handled on a monthly basis rather than on a semi-weekly basis henceforth, so that the number of checks written can be substantially reduced, thus involving more businesslike and accurate procedures. Payment to physicians will be converted to an IBM mechanism on or about July 1, although payment to subscribers who are attended by nonparticipating physicians will continue to be handled manually. The comptroller's office has been assigned the preparation of vouchers inasmuch as this is primarily an accounting procedure.

The claims division, under the direction of Mr. Doran, has been organized and its duties defined, so that there now stands in the matter of handling claims a division which clears routines such as the fact that the claimant has paid his premium, the type of contract under which he is covered, and similar details. Claims are then processed for payment through the claims division, referred to the accounting division for the preparation of checks, and the vouchers are returned to business administration for signature and mailing.

There are many matters of consequence to the sound development of Blue Shield of Wisconsin. Because of the utilization of the IBM check for voucher writing, it will now be possible for Blue Shield to maintain its own statistical information in such manner as to be highly accurate and readily available. This fact, along with other problems, indicates the necessity, at a reasonably early date, of renegotiating the contract with Blue Cross under which a formula exists for payment to Blue Cross of its expense in handling Wisconsin Physicians Service sales, enrollment, and billing efforts. At the present time Blue Shield is remitting to Blue Cross approximately $200,000 annually for these services, with Blue Shield of Milwaukee remitting a somewhat larger, but proportionate amount. Between the two Blue Shield plans, approximately 40 per cent of practically all administrative expense of Blue Cross is reimbursed. Only a few items are excluded, such as attorneys' fees, certain convention expense, and similar items.

It is only prudent that periodic re-evaluation of the agency contract be undertaken, that Blue Shield of Wisconsin remit to Blue Cross an amount which has been determined to be quite accurate in reflecting Blue Cross expense in handling Blue Shield of Wisconsin.

The Commission on Prepaid Plans, through the Executive Committee, emphasizes to the Council and officers that the staff of Blue Cross holds a dual loyalty, which must be recognized by all concerned. The staff constitutes those employed by Blue Cross, but by contract with Blue Shield the staff holds definite obligations to it. All of these considerations must be weighed in the determination of any policy with respect to the future of the program.

The Commission on Prepaid Plans, through its officers and staff, felt it necessary that the Board of Directors of Associated Hospital Service have full information concerning the plans and the progress of Blue Shield of Wisconsin. However, the Board has requested that such information be routed to it only through the executive officers in Milwaukee. The Commission is, of course, agreeable to that policy so long as it can be assured that the Board of Directors of Blue Cross, like the Council and officers of the State Medical Society, are apprised of every important development.

In future meetings of the Council and officers, reports of the Commission on Prepaid Plans will be pointed to particular phases of its operations, such as financial experience, enrollment, physician and public relations, and similar matters.

It is planned in the future that there be periodic meetings between Blue Cross and Blue Shield at which physician representation as well as representation from the Board of Directors of Blue Cross will be present.

Councilors and officers are also advised that regular monthly meetings have been held over some period of time, and are planned for the indefinite future, between the executive staffs of Blue Cross and Blue Shield.

This report is intended only to touch upon various high lights of the past five months, and can be elaborated upon in discussion before the Council and officers to the extent desirable.

Respectfully submitted,
EXECUTIVE COMMITTEE OF THE
COMMISSION ON PREPAID PLANS
E. M. DESSLOCH, M.D., *Chairman*
H. E. KASTEN, M.D.
J. S. SUPERNAW, M.D.
ROBERT KROHN, M.D.

On motion of Doctors Galasinski–Kidder, carried, the Council approved the report of the Commission on Prepaid Plans.

12. Report of the Subcommittee on Epilepsy and Marriage

The Committee on Mental Hygiene, Institutional Care, and State Departments has been studying through its subcommittee the problem of epilepsy and marriage. Drs. Mabel Masten, Madison, and E. D. Schwade, Milwaukee, members of the subcommittee were present to discuss the problem with the Council.

Doctor Schwade stated that as a result of the subcommittee's study the suggestion had been made that legislation be introduced at the next legislative session to amend Section 245.03 (1) of the Wisconsin Statutes, which provides in part that: "No insane, imbecile, feeble-minded or epileptic person or idiot shall be capable of contracting marriage."

Doctor Schwade pointed out in an extensive report that the epileptic person is a normal person except for his epileptic seizures, and in no wise is he a mentally ill person. The subcommittee, therefore, recommended that the words "epileptic person" be deleted from the law.

Doctor Masten felt that the law as it stands now is discriminatory. Other disorders with a hereditary factor are not specifically specified in the law. It is impossible to predict what persons may have epilepsy if there is no epilepsy in the family. From statistical study, it is known that where one parent has epilepsy, the incidence of epilepsy in the offspring is less by 10 times than migraine. Yet, the offspring from migranous parents with epilepsy giving rise to offspring with epilepsy is far greater than parents with epilepsy.

On motion of Doctors Dessloch–Bell, carried, the Council approved the recommendation of the Subcommittee on Epilepsy and Marriage that the Committee on Public Policy introduce legislation which will revise the wording of Section 245.03 (1) of the Wisconsin Statutes, to delete the words "epileptic person" from that section which reads in part: "No insane, imbecile, feeble-minded or epileptic person or idiot shall be capable of contracting marriage."

13. Report of the Committee on Audit and Budget

Doctor Dessloch reported that the committee had two recommendations to make. First, inasmuch as the premium structure has been increased in Blue Shield and since the Society employees are covered under it, when full installation of the new plan takes place, there would be an increased cost to the Society in increased premiums for employees. The Audit and Budget Committee recommended that the B schedule be installed immediately for Society employees and the A schedule when Wage Stabilization Board acts in favor of it, and that a deficiency appropriation be made in the account to cover it.

It was moved by Doctors Zellmer–Kidder, carried, that the Council approve installation of the B schedule for Society employees, and subject to Wage Stabilization Board approval, the A schedule be made available to eligible employees.

Secondly, the Council on Medical Service requested that approval be given to a first-aid chart which would be distributed to physicians' offices, 4–H Clubs, and other organizations which have indicated their desire for such a chart. The charts could be provided at a cost of about $650. Those who can afford to buy them would pay for them. The Audit and Budget Committee recommended that the doctor's telephone number be deleted from the chart, and the words "Call Doctor Immediately" or some similar wording be substituted. In addition, the committee recommended that the word "antiseptic" be deleted in two places. With these suggestions, the committee recommended approval of the first-aid chart, and appropriation of $650 from Society funds for the printing of the chart.

On motion of Doctors Hemmingsen–Bell, carried, the chart was approved as amended, and the appropriation was approved.

Doctor Dessloch further discussed another proposal to come before the Audit and Budget Committee. An appropriation was granted to the State His-

torical Society in 1951 for a study of medical history conducted by Don McNeil. Mr. Clifford Lord, director of the Historical Society, suggested a budget for the coming year to be composed as follows: Salary, $3,600; travel, $1,500, making a total of $5,100.

The Audit and Budget Committee felt that the Society could not contribute this amount in full and on motion of Doctors Dessloch–Bell, carried, the committee's recommendation that $2,500 be allocated for this study was approved.

14. Report of Secretary

The secretary apprised the Council of considerations that are being given to relieve the crowded working conditions in the State Society offices, due to the addition of some twenty employees in the administration of Wisconsin Physicians Service, the installation of new IBM and other equipment, and the like. He stated that city ordinances require that parking space equivalent to the square footage of the building be provided on contiguous property. It does not seem likely that the city will vacate the street end adjoining the lakeshore lot behind the building, but if the lot across the street, behind the Cancer Society building, could be acquired, it might be regarded as contiguous for parking purposes. This would permit constructing further office space behind the present building. He proposed that a separate corporation be created to handle the financing of acquisition of property and building construction.

The secretary reported, in response to a question raised by the Council, that practically all essential positions in the office are being understudied. He expressed the hope that the Council and officers, with respect to the entire structure of the State Medical Society, would permit at a subsequent meeting an informal round table discussion by the staff as to their activities and the integration of separate projects into the over-all picture.

15. State Department of Public Welfare

Mr. John W. Tramburg, Director of the State Department of Public Welfare, and Mr. George M. Keith, Director of the Division of Public Assistance, were present Sunday morning to discuss with the Council matters of mutual concern.

Mr. Tramburg reported that a program had recently been worked out with the University of Wisconsin Medical School for the training of psychiatrists through a fellowship program. Three years will be spent in residency at Wisconsin General Hospital, and two years of service in the state institutions. It is anticipated that some sorely needed psychiatrists receiving this training will be retained in the state institutions under the direction of the State Department of Public Welfare. He said it is hoped this program will provide some auxiliary training facilities in the fields of psychiatric social work and psychiatric nursing.

Mr. Tramburg said that the Board of Public Welfare was considering a recommendation for the consolidation of the Boys and Girls Schools and would call upon the State Medical Society for its opinion as to whether this would be desirable and workable.

He asked the Council for its advice and counsel in the recruitment of physicians to service in the state charitable, curative, and correctional institutions.

Mr. Keith discussed the problem of the medical care of persons receiving public assistance. He reviewed the history of the public assistance program, and the roles played at the county, state, and federal levels, the method of financing, administration, and the body of law involved. He said that if a movement grows to establish fairly uniform standards of public assistance on a state-wide basis, including medical care, the department will need an even closer relationship with the medical profession through advisory committees in standardizing fee schedules and types of medical care. Mr. Keith said the welfare departments have appreciated the assistance of the auditing committees of county medical societies in reviewing medical bills of persons receiving public assistance.

16. Report of Committee on Maternal and Child Welfare

The committee had requested authority in its report to the House of Delegates last October to conduct a state-wide study of maternal and neonatal deaths, subject to review and approval of the Council.

Mr. Ragatz, on behalf of Dr. T. A. Leonard, chairman of the subcommittee appointed to make the study, requested Council approval to a form that has been developed to implement the study of maternal deaths, and authority to proceed. The committee intends to make the maternal mortality study before proceeding with the study of stillbirths and neonatal deaths.

On motion of Doctors Kidder–Hemmingsen, carried, the Council approved the report form and authorized the study.

17. River Falls Situation

A citizens committee from River Falls, Wisconsin had appeared before the Interim Committee at its May 17, meeting regarding the refusal of the medical physicians in the area to use the River Falls Hospital which had on its staff an osteopath. The citizens committee requested the Interim Committee to set out in a letter the opinion of the medical profession with respect to the situation.

On motion of Doctors Dessloch–Bell, carried, the letter to the citizens committee of River Falls was approved.

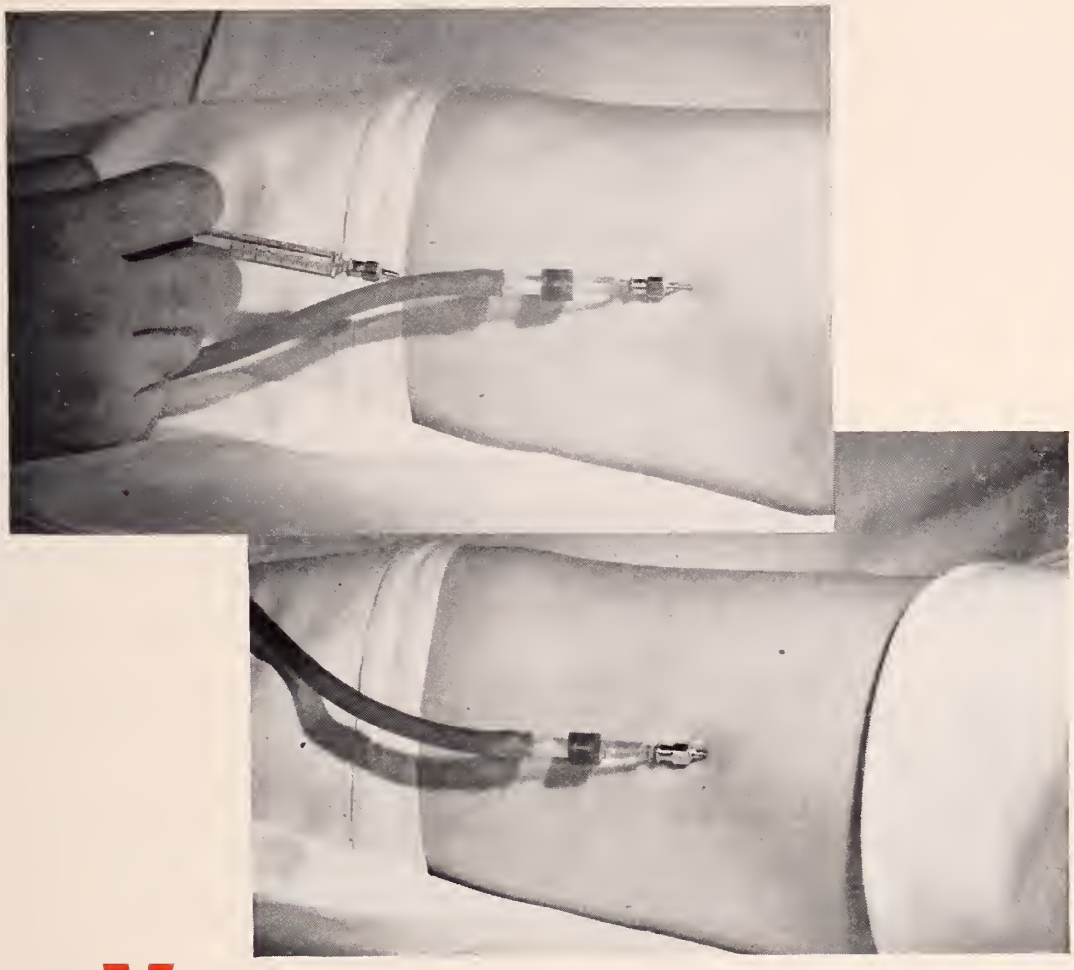
18. Adjournment

The meeting adjourned at 12:30 p.m., Sunday, May 18, 1952.

C. H. Crownhart
Secretary

Approved:

R. G. Arveson, M.D.
Chairman of the Council



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RESEARCH IN THE SERVICE OF MEDICINE

The Laboratory Approval Program

As It Looks to the State Board of Health

THE 1951 state legislature provided for a method of evaluating laboratory services under the supervision of the State Board of Health. The Board in starting this program has limited its original work to laboratories performing bacteriological analyses of water and milk.

The program is a voluntary one in that laboratories desiring approval must apply for it. However, grade A milk plants that ship milk out of state are required to have their bacterial quality tests made in laboratories approved by the state, and milk plants in cities and villages in Wisconsin that bottle grade A milk are required to have their official laboratory work done in approved laboratories.

One cannot write about a milk or water laboratory approval program without mentioning "Standard Methods," a manual published by the American Public Health Association. The first edition of this manual which described standard procedures for performing bacteriological analyses of milk was published about a half century ago. The purpose of the manual was and still is to provide methods that will make the results of milk and water examinations uniform regardless of where they are performed. Pioneers in dairy bacteriology realized that slight differences in procedure gave results that were entirely different.

The first standard methods committee, of which Dr. H. L. Russell of Madison was a member, wrote up detailed methods for estimating bacteria in milk. Since that time nine editions of "Standard Methods" have been published. Committees are usually composed of half a dozen or more authorities from the United States and Canada so each edition represents a blend of current opinions of recognized experts in their respective fields. This policy of continuous revision permits "Standard Methods" to keep up-to-date with new, improved techniques.

With the standard manual available, the real problem is to have technicians and laboratory directors interpret "Standard Methods" in the same way and actually follow a uniform procedure closely. Not until 1941 was the size of the problem recognized. At that time Luther A. Black, a bacteriologist from the U. S. Public Health Service, became interested in finding out if technicians all over the United States actually counted bacteria in milk according to the method described in "Standard Methods."

Mr. Black went from laboratory to laboratory in the 48 states and talked with laboratory directors and technicians. He examined their equipment and watched them perform their examinations. The results of Black's survey were surprising. All the laboratory people he talked with were intending to follow the standard procedure. But when checks were made of the equipment and technique not one laboratory out of over 400 was following "Standard Methods" in all details.

Some of the more frequent deviations that Black found on his visits to these laboratories were as follows: poor technique, broken tipped pipettes, incorrectly filled dilution bottles, improperly operated hot air ovens, and incubators that were not checked for temperature variations. Practically every item of procedure was violated by some laboratory sufficiently to influence the accuracy of the analysis.

In a recent survey in Wisconsin only 3 out of 36 laboratories were using methods that were substantially in compliance with "Standard Methods." However, a considerably larger number have made the necessary corrections and have now received their certificates of approval.

Several reasons have been suggested for the large number of variations in technique found in milk and water laboratories: one results from the apparent simplicity of some of the techniques used in sanitary bacteriology. This has led some public health administrators to employ persons who do not fully realize the need for exactness in the performance of these procedures. Another reason is that universities have not always had the facilities or the time to teach "Standard Methods" technique.

The educational approach to solving this problem included a five day milk laboratory workshop held in Madison last spring to inform or refresh the trainees in "Standard Methods" procedures. The course included lectures and laboratory periods in which the class actually performed the various examinations. A correction of errors was made. Additional individual instruction has been given to laboratory personnel in their own laboratories upon request.—D. I. THOMPSON, *Director of Laboratory Certification.*

AMERICAN ASSOCIATION OF BLOOD BANKS TO MEET IN MILWAUKEE

The American Association of Blood Banks will hold its fifth Annual Meeting at the Hotel Schroeder in Milwaukee, October 9, 10, and 11. All those concerned with blood banking and blood transfusions will find this meeting of great interest. A refresher course for blood bank technicians will be given. Individual registration fee for the convention is $5.00.

Further information may be obtained by writing to Mr. R. F. Ambelang, business manager, Junior League Blood Center of Milwaukee, Inc., 763 North Eighteenth Street, Milwaukee 3, Wisconsin.

SMS SPONSORS FIRST STATE CONFERENCE ON PHYSICIANS AND SCHOOLS

MEMORIAL UNION, MADISON — OCTOBER 17–18

The State Medical Society is the major sponsor of the first state-wide conference on PHYSICIANS AND SCHOOLS, which will be held in Madison on October 17–18, and all physicians identified with school activities are urged to attend. Those who are school board members, local health officers, pediatricians, and public health officers will be especially interested in the program.

This conference is a "follow up" of three national conferences sponsored by the Bureau of Health Education of the American Medical Association, held in 1947–49–51, and two members of the A.M.A. staff responsible for the national conferences will be in attendance at our state meeting. W. W. Bauer, M. D., director of the Bureau of Health Education and a former health commissioner of the city of Racine, will be the featured speaker on the opening program, while Fred Hein, Ph. D., former health educator in Oshkosh and now a special consultant to Doctor Bauer's department, will be a roving consultant, and will summarize the conference at the end of the program.

Wisconsin physicians actively identified with the conference by way of participation in the program are: Drs. Maxine Bennett, Madison; G. F. Burgardt, Wauwatosa; Eugenia Cameron, Madison; C. M. Carney, Beloit; Marie Carns, Madison; Frances Cline, Rhinelander; E. F. Cook, Milwaukee; Francis De Salvo, Wausaukee; A. C. Edwards, Racine; J. C. Griffith, Milwaukee; Margaret L. Hatfield, Milwaukee; A. H. Heidner, West Bend; James A. Johnson, Milwaukee; H. J. Kief, Fond du Lac; W. R. Manz, Eau Claire; Mabel Masten, Madison; F. J. Mellencamp, Milwaukee; C. F. Midelfort, La Crosse; C. N. Neupert, Madison; E. H. Pawsat, Fond du Lac; E. B. Pfefferkorn, Oshkosh; A. A. Pleyte, Milwaukee; G. M. Shinners, Green Bay; W. D. Stovall, Madison; M. W. Stuessy, Brodhead; H. Kent Tenney, Madison; and A. R. Zintek, Milwaukee.

Details of the program are as follows:

Friday, October 17

10:00–11:00 **Registration**—Upper Level, Great Hall, Memorial Union

Coffee Hour—East End, Great Hall

11:00–12:45 **First General Session**—Great Hall: Presiding, Mr. Fred Holt, Chairman, Wisconsin State School Health Council

Welcome: President Fred, University of Wisconsin; and A. H. Heidner, M.D., Past-President, State Medical Society of Wisconsin

"Our Stake in a Good School Health Program in Wisconsin:" George Watson, State Superintendent of Public Instruction; C. N. Neupert,

M.D., State Health Officer; Mrs. Joseph Born, President, Wisconsin Congress of Parents and Teachers

"What This Conference Should Accomplish:" W. W. Bauer, M.D., Director of Health Education, American Medical Association

Conference Plan: F. J. Mellencamp, M.D., Milwaukee, Chairman, Committee on School Health, State Medical Society of Wisconsin

1:00 **Luncheon** — Tripp Commons: Presiding, R. F. Lewis, First Assistant Superintendent of Public Instruction

Introduction of Speaker: Mr. Angus Rothwell, Superintendent of Schools, Manitowoc

"Let's Really Do a Job:" Clyde Parker, Superintendent of Schools, Cedar Rapids, Iowa; Chairman, Commission which prepared yearbook: "Health in Schools" for the American Association of School Administrators

2:15– 3:30 **Workshop Discussion Groups**

3:45– 5:15 **Workshop Discussion Groups**

6:30 **Dinner** — Tripp Commons: Presiding, John Guy Fowlkes, Ph.D., Dean, School of Education, University of Wisconsin

Introduction of Speaker: Warren H. Southworth, D.P.H., University of Wisconsin

'The Doctor Looks at School Health:" George M. Wheatley, M.D., Metropolitan Life Insurance Company, New York City

Entertainment: Showing of movies of Ohio State–Wisconsin football game on October 11.

Saturday, October 18

9:30–11:00 **Workshop Discussion Groups**

11:00–11:30 **Intermission**

11:30– 1:30 **Luncheon** — Tripp Commons: Presiding, J. C. Griffith, M.D., Milwaukee, President, State Medical Society of Wisconsin

1. **Reports of Work Sessions:** (10 minutes each): Recorders of Sections
2. **A General Evaluation of the Conference:** Fred V. Hein, Ph.D., Consultant, Bureau of Health Education, American Medical Association, Chicago
3. Address by W. D. Stovall, M.D., Director, State Laboratory of Hygiene, Madison

ADJOURNMENT

WORKSHOP DISCUSSION GROUP MEETINGS

FIRST MEETING OF WORKSHOPS

Friday, October 17—2:15–3:30 p. m.

HEALTH EXAMINATIONS: Reception Room

Chairman: E. H. Pawsat, M.D., Fond du Lac, Health Chairman, Wisconsin Congress of Parents and Teachers

Recorder: Maxine Bennett, M.D., Medical Director, Bureau of Handicapped Children, Department of Public Instruction, Madison

Topic: Organization and Guiding Principles

Panel: Frances Cline, M.D., District Health Officer, Rhinelander—Robert Halmstad, Superintendent of Schools, Chippewa Falls—Josephine Miller, R.N., Washington County Public Health Nurse, West Bend—Millard Murphy, Ph.D., Health Coordinator, Wisconsin State College, La Crosse—Harry Olson, Superintendent of Schools, Oconomowoc

CONTROL OF DISEASE—Round Table Room

Chairman: George Shinners, M.D., District Health Officer, Green Bay

Recorder: Harley J. Powell, Superintendent of Schools, Wauwatosa

Topic: Transmission of Infection, Detection and Exclusion

Panel: Francis DeSalvo, M.D., Wausaukee—Lillian Simonson, Principal, Marquette Elementary School, Madison—Elizabeth Winpenny, R.N., Polk County Public Health Nurse, Balsam Lake—A. R. Zintek, M.D., Northwestern Life Insurance Company, Milwaukee

EMERGENCY CARE IN SCHOOLS: Rosewood Room

Chairman: Leslie Johnson, Superintendent of Schools, Superior, and President of the Wisconsin Education Association

Recorder: Emma Erickson, Principal, Franklin Elementary School, La Crosse

Topic: First Aid: Equipment, Policies

Panel: M. J. Gegan, Superintendent of Schools, Menasha—Lucille Rabe, R.N., Public Health Nurse, New London—Frank Stangel, Supervisor of Health Education, Milwaukee Public Schools—George Steiner, Assistant Principal, West High School, Madison—M. W. Stuessy, M.D., Brodhead

PHYSICAL EDUCATION, ATHLETICS AND RECREATION: Room, Loft

Chairman: Homer De Long, Superintendent of Schools, Eau Claire

Recorder: Ruth Palmer, President, Wisconsin Association of Health, Physical Education and Recreation, Kenosha

Topic: Physical Education: Objectives, Medical Excuses, Modification of Student Programs

Panel: Marie Carns, M.D., Director, Women's Physical Education Department, University of Wisconsin—V. E. Klontz, Superintendent of Schools, Janesville—Emma Wilder, Assistant Director, Physical Education Department, Wisconsin State College, La Crosse—Jane Whitney, Supervisor of Girls' Physical Education, Milwaukee Public Schools—Lester Wilke, Supervisor of Elementary Health and Physical Education, Sheboygan Public Schools

EMOTIONAL PROBLEMS OF THE GROWING CHILD: Room, Top Flight

Chairman: H. Kent Tenney, M.D., Madison

Recorder: Lloyd V. Ballard, Ph.D., Director, Department of Sociology, Beloit College

Topic: Manifestations and Scope of the Problem

Panel: A. B. Abramovitz, Supervisor of Clinical Psychologists, State Board of Health, Madison—Mrs. Otto Falk, Executive Secretary, Wis-

(Continued on page 936)

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W. D. STOVALL

consin Public Health Council, Wauwatosa—James A. Johnson, M.D., Child Guidance Center, Milwaukee—H. G. Knudtson, Superintendent of Schools, Two Rivers—John Mann, Superintendent of Schools, Appleton

SECOND MEETING OF WORKSHOPS

Friday, October 17—3:45–5:15 p. m.

HEALTH EXAMINATIONS: Reception Room

Chairman and **Recorder** same as First Meeting

Topic: Type and Frequency: Readiness, Referral, Routine, Special Emphasis and Scope of Examination

Panel: Marshall Batho, Graduate Research, University of Wisconsin School of Education—Lester Gerlach, D.D.S., Milwaukee—Florence Gurholt, R.N., Dane County Health Department, Madison—Harold Kief, M.D., Fond du Lac—Eleanor O'Meara, R.N., District Advisory Nurse, Green Bay

CONTROL OF DISEASE—Round Table Room

Chairman and **Recorder** same as First Meeting

Topic: Permits for Reentry, Makeup Work, Special Health Problems

Panel: Orvus Dodsworth, Superintendent of Schools, Medford—A. C. Edwards, M.D., Commissioner of Health, Racine—Mrs. Ella Heim, R.N., Public Health Nurse, Watertown—Geneva McDonald, Principal, Shorewood Hills Elementary School

EMERGENCY CARE IN SCHOOLS: Rosewood Room

Chairman and **Recorder** same as First Meeting

Topic: Home Information: Getting Injured Children or Ill Children Home, Permission to Call Physician, Home and School Responsibility

Panel: Sheridan Ellsworth, Walworth County Superintendent of Schools, Elkhorn—W. W. Engelke, Principal, Nakoma Elementary School, Madison—Margaret L. Hatfield, M.D., Deputy Commissioner of Health, Milwaukee—Harold B. Mennes, Superintendent of Schools, Neenah—Lauretta Peterman, R.N., Lincoln County Public Health Nurse, Merrill

PHYSICAL EDUCATION, ATHLETICS AND RECREATION: Room, Loft

Chairman and **Recorder** same as First Meeting

Topic: Athletics: Examination of Athletes (Frequency, Scope, Follow-Through), Elementary and Junior High School Interscholastic Competition

Panel: Edwin Hoppe, Director of Physical Education, Milwaukee Public Schools—Robert Francis, Ph.D., Department of Physical Education, University of Wisconsin—Roland Klaus, Superintendent of Schools, Edgerton—Walton Manz, M.D., Eau Claire

EMOTIONAL PROBLEMS OF THE GROWING CHILD: Room, Top Flight

Chairman and **Recorder** same as First Meeting

Topic: Detection and Referral: Role of the Family Physician, Child Guidance Centers and Special Services; Schools and Social and Health Agencies

Panel: Eugenia Cameron, M.D., Director, Mental Health Division, State Board of Health, Madison—Leona McGann, Medical Social Worker, Bureau of Handicapped Children, Department of Public Instruction, Madison—C. F. Midelfort, M.D., La Crosse—Carl Waller, Guidance Director, Madison Public Schools

THIRD MEETING OF WORKSHOPS

Saturday, October 18—9:30–11:00 a. m.

HEALTH EXAMINATIONS: Reception Room

Chairman and **Recorder** same as Friday Meetings

Topic: Records and Follow Through

Panel: Gerald Burgardt, M.D., Wauwatosa—Josephine Hintgen, Assistant Superintendent of Schools, La Crosse—Frank Powell, Director, Bureau of Handicapped Children, Department of Public Instruction, Madison—Ione Rowley, R.N., Assistant Director, Public Health Nursing, State Board of Health, Madison—L. O. Tetzloff, Principal, Sheboygan County Rural Normal School, Sheboygan Falls

CONTROL OF DISEASE—Round Table Room

Chairman and **Recorder** same as Friday Meetings

Topic: Periodic Health Examinations and Chest X-Rays of School Personnel

Panel: G. W. Bannerman, Superintendent of Schools, Wausau—Lillian Lyons, R.N., Public Health Nurse, Menasha—E. B. Pfefferkorn, M.D., Oshkosh—A. A. Pleyte, M.D., Medical Director, W.A.T.A., Milwaukee

EMERGENCY CARE IN SCHOOLS: Rosewood Room

Chairman and **Recorder** same as Friday Meetings

Topic: Accident Insurance: Scope of W.I.A.A. Program, Complaints of M.D.s, School Responsibility

Panel: C. M. Carney, M.D., Beloit—Clifford Fagan, Executive Director, W.I.A.A., Marinette—J. R. Gerritts, Principal, Kimberly High School—R. G. Hein, Superintendent of Schools, Waukesha

PHYSICAL EDUCATION, ATHLETICS AND RECREATION: Room, Loft

Chairman and **Recorder** same as Friday Meetings

Topic: Recreation: The Intramural Program, School and Community

Panel: Harold Bauer, Superintendent of Schools, Fond du Lac—Emmett Cook, M.D., President, Milwaukee School Board—Allan Gabrilska, Senior High School, Wausau—Glenn Holmes, Director of Recreation, Madison Public Schools —Theresa Statz, Bayview High School, Milwaukee

EMOTIONAL PROBLEMS OF THE GROWING CHILD: Room, Top Flight

Chairman and **Recorder** same as Friday Meetings

Topic: Special Problems, Absenteeism (health, non-health, psychosomatic, emotional), School Readiness, The Handicapped Child—Slow Learner, Epileptic, and Pupils with Sensory Defects

Panel: Elaine Burnham, Clinical Psychologist, Waukesha—James Luther, Superintendent of Schools, Fort Atkinson—Mabel Masten, M.D., University of Wisconsin Medical School—Margaret Parker, Supervisor Teacher, Vilas County Schools, Eagle River—Harold Williams, Ph.D., Psychologist, Bureau of Handicapped Children, Department of Public Instruction, Madison

NOTE: *All sessions will open with short presentations by panel participants, after which there will be general discussion and comments from the audience. Each session will be restricted to discussion of questions supplied at time of registration.*

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J. Frampton Wyman, M. D. — Lloyd F. Jenk, M. D.
Hubert H. Blanchard, M. D. — James F. McDonald, Jr., M. D.

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SOCIETY PROCEEDINGS

Fond du Lac

On May 29 a new medical library at the St. Agnes Hospital in Fond du Lac was dedicated to the memory of the late Lieutenant Robert C. Gavin, medical corps, United States Navy. The son of *Dr. and Mrs. S. E. Gavin* of Fond du Lac, Lieutenant Gavin was lost at sea on Dec. 18, 1944, in a typhoon.

Dr. L. C. Gardner, chief of staff at St. Agnes Hospital, presented an inscribed plaque on behalf of the medical society to Sister M. Juliana as a representative of the hospital staff. All members of the medical society and the staff of the hospital participated in the program of establishing this memorial by turning over a fund for investment, and the proceeds will be used as an endowment.

Green Lake–Waushara

The Green Lake–Waushara County Medical Society held its annual shore dinner on July 31 at Sugar Loaf, a landmark on Green Lake. Following dinner, a meeting was held at the home of *Dr. Alfred T. Leininger* in Green Lake. There were no formal papers presented, but *Dr. John A. Van Susteren*, Sparta, district health officer and Miss Irene Lewis, Green Lake county nurse, led a discussion on pre-school examinations and immunization clinics. The Society also approved the Red Cross blood donation program in Waushara County as requested by that Chapter of the American Red Cross.

Richland

Fifteen members of the Richland County Medical Society were present at the June meeting of the Society, held at *Dr. W. C. Edwards'* cottage at Riverview. Dr. George Benson, a member of the staff of the Veterans Administration Hospital, Madison, was the guest speaker for this occasion. His subject was "Rehabilitation of Handicapped Persons."

Trempealeau–Jackson–Buffalo

Dr. F. T. Weber, Arcadia, president of the Trempealeau–Jackson–Buffalo County Medical Society, presented a life membership certificate to *Dr. H. A. Jegi* of Galesville, when the Society met on July 17 at Fountain City. Another feature of this meeting was a talk by Mr. Thomas J. Doran of the State Society on problems relative to Welfare Departments.

Wood

The scientific session of the July 31 meeting of the Wood County Medical Society, held in Marshfield at the Hotel Charles, consisted of the presenta-

The picture above was taken at the dedication ceremonies of the new medical library at the St. Agnes Hospital in Fond du Lac. Sister M. Juliana is shown accepting the plaque from Dr. L. C. Gardner.

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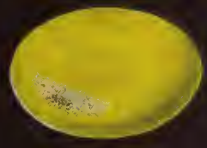

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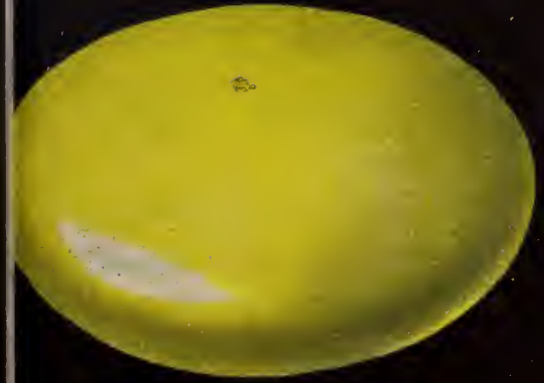

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tion of two papers. Dr. G. E. Magnin, who recently joined the staff of the Marshfield Clinic, spoke on "The Use of Aminopterin in Acute Leukemia," and *Dr. Marvin Jaffee* of Nekoosa chose "Peripheral Vascular Disease" as the subject of his paper.

American Academy of General Practice Fond du Lac Chapter

The Fond du Lac Chapter of the American Academy of General Practice held its most recent meeting on July 17 at the Waupun Hotel in Waupun. The guest speaker was *Dr. E. P. Roemer* of Madison, director of the Wisconsin Neurological Foundation. Doctor Roemer's paper was entitled "Rehabilitation of Neurological Patients."

The annual election of officers was held at this meeting. *Dr. K. K. Borsack*, Fond du Lac, assumed the office of president, and the following physicians were elected to serve with him: *R. S. Pelton*, Markesan, president-elect; and *R. L. Waffle*, Fond du Lac, secretary–treasurer.

Wisconsin Urological Society

The annual meeting of the Wisconsin Urological Society was held in Milwaukee on April 26, at Milwaukee County Hospital. A day long scientific program was presented, as well as a business meeting to elect officers. The speakers and their subjects at the morning meeting were as follows: "Spina Bifida —Associated Urological Problems Encountered," by *Dr. J. W. Shaw*, Manitowoc; "Porphyria in Two Sisters," by *Dr. B. H. Brunkow*, Monroe; "Vesical Diverticulum: Clinical Features and Experience with a Transvesical Type Operation," by Dr. W. J. Engel, Cleveland, Ohio; "Supra-Pubic Approach to Repair of Stress Incontinence and Vesico-Vaginal Fistula," by *Dr. W. M. Kearns*, Milwaukee; "One State Supra-Pubic Prostectomy with Closure of the Bladder," by *Drs. J. J. Mueller* and *G. H. Ewell*, Madison; and "Carcinoma of the Ureter," by *Dr. A. P. Schoenenberger*, Madison.

During the afternoon, the speakers were as follows: *Dr. L. E. Plank*, Wood, "Hyperparathyroidism;" Dr. E. I. Prien, Brookline, Mass., "Medical Management of Urinary Calculi;" *Dr. N. W. Bourne*, Milwaukee, "Pyelograms in Children;" *Dr. I. E. Kolman*, Madison, "Unusual Hypernephromas;" and *Dr. R. A. Wood*, Sheboygan, "Thoraco–Lumbar Nephrectomy."

The officers elected for the coming year were *Dr. S. A. Freitag*, Janesville, president; *Dr. E. B. Jacobson*, Milwaukee, vice-president; and *Dr. E. F. Cummings*, Oshkosh, secretary–treasurer.

News Items and Personals

Fond du Lac Clinic Has New Associate

Dr. Hugh J. McLane, former resident physician at the Henry Ford Hospital in Detroit, will shortly move to Fond du Lac where he will become associated with the Fond du Lac Clinic. The doctor is a graduate of the Yale University School of Medicine and served his internship at the Rhode Island General Hospital.

New Doctor Joins Staff of Grant Community Hospital

Drs. H. W. Carey and *K. L. Bauman* of Lancaster have announced an addition to the medical staff at the Grant Community Hospital. On July 1 they were joined by *Dr. Leo E. Becher* of Milwaukee, a 1950 graduate of Marquette University School of Medicine, and formerly a resident physician at St. Michael's Hospital in Milwaukee.

Doctor Aldridge Certified by Specialty Board

Dr. C. W. Aldridge, Jr., Appleton, recently received certification from the American Board of Obstetrics and Gynecology, as the result of successfully passing the examinations which were held in Chicago on June 9. A graduate of the University of Michigan Medical School, the doctor has been practicing in Appleton for two and one-half years.

Doctors Buckley and Walter to Be Associated

Dr. R. A. Buckley, Eau Claire, has announced that as of July 1, Dr. Karl E. Walter has become associated with him in the practice of medicine. Doctor Walter, who is a graduate of the St. Louis University School of Medicine, recently received his discharge from the strategic air command after serving two years in charge of the dependents clinic at the Offutt Air Force Base near Omaha, Nebraska.

Physician Opens Office in Clintonville

On July 16, Dr. Owen E. Larson, who recently completed a residency in surgery at the Veterans Administration Hospital, Wood, opened an office in Clintonville. A native of Appleton, Doctor Larson was graduated from Marquette University School of Medicine. He interned at Harper Hospital, Detroit, Mich., and was also affiliated in pediatrics with the Children's Hospital of Michigan.

Doctor Lokvam Returns to Practice

Dr. Leif H. Lokvam of Kenosha, who left his practice last November because of illness, returned to his office August 4. His field of practice will be limited to general surgery and surgery of trauma. Since May of this year he has been in attendance

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Medicines in Hospital	10.00	20.00	30.00	40.00
Ambulance to or from Hospital	10.00	20.00	30.00	40.00
COSTS (Quarterly)				
Adult	2.50	5.00	7.50	10.00
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at the surgical clinics at the Lahey Clinic in Boston. At the close of the school year his family joined him in the East.

Doctor Lokvam is a Fellow of the American College of Surgeons and a member of the Wisconsin Surgical Society.

Radiologist Opens Office in Kenosha

Dr. Harold A. Bjork of Chicago recently opened an office in Kenosha and will specialize in radiology. A graduate of the Rush Medical College of the University of Chicago, the doctor interned at Mercy Hospital, Loyola University Clinics, in Chicago prior to entering the armed forces during World War II. Upon his discharge, he established a general practice in St. Joseph, Mich., for three years before accepting a three year fellowship in x-ray training at St. Luke's Hospital, Chicago.

New Glarus Doctor Has Associate

During the first week in July, *Dr. E. V. Hicks*, New Glarus, opened his new office building and announced that Dr. E. K. Rath of Milwaukee would be associated with him in practice. A native of Milwaukee, Doctor Rath is a graduate of the Marquette University School of Medicine and served his internship at Mercy Hospital in Janesville. The new office building has a gray stone exterior and the interior is finished in knotty pine.

New Staff Member at River Falls Clinic

Dr. Paul S. Haskins, who was recently released from the Navy after two years active duty, has become associated with the River Falls Clinic. Born in La Crosse, Doctor Haskins attended the University of Richmond, Virginia, for his pre-medical education, graduated from the University of Wisconsin Medical School in 1949, and interned at St. Joseph's Hospital, Marshfield.

THIRD AND TWELFTH DISTRICT NEWS

Doctor Establishes Office in Middleton

Dr. Thomas F. Heighway, who until recently was director of the student health service and college physician of Knox College in Galesburg, Ill., has opened an office in Middleton, where he plans a general practice of medicine, surgery, and obstetrics. The doctor graduated from Northwestern University Medical School in 1946 and interned at Wesley Memorial Hospital, Chicago. He served with the Armed Forces in the U. S. Public Health Service on the attending staff of the U. S. Marine Hospital in Seattle, Wash., until 1949.

Internist Starts Practice in Madison

Dr. Royal Rotter, who for the past three years has been affiliated with Wisconsin General Hospital,

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*Sobel, S. H.: Milk Allergy in a case of Triplets, *Clin. Med.*, August 1952.

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has announced the opening of his office in Madison for the practice of internal medicine. He is a graduate of the University of Wisconsin Medical School and served his internship at Michael Reese Hospital, Chicago. He was later awarded a fellowship by the Hematologic Research Foundation for the study of leukemia and other blood diseases.

Doctor Lubing Moves to Madison

H. N. LUBING

Dr. Harold N. Lubing, who for the past three years has been clinical director of the Winnebago State Hospital, has opened an office in Madison for the practice of psychiatry and neurology. Doctor Lubing, a graduate of the University of Wisconsin Medical School, interned at Mt. Sinai Hospital, Chicago, and served three years as a resident in neuropsychiatry at Wisconsin General Hospital. He also served for a year on the staff of the Institute of Living at Hartford, Conn. He is a diplomate of the American Board of Psychiatrists and Neuropsychiatrists.

U. W. Holds "Health Day" for Executives

One of the features of the four week course conducted for executives of Wisconsin industries by the University of Wisconsin Industrial Management Institute was a "Health Day." The program was under the general chairmanship of *Dr. J. W. Brown*, professor of preventive medicine at the University, and Mr. Baird Tenney, son of *Dr. H. Kent Tenney*, Madison. Drs. Brown, *Hans Reese, R. N. Allin, G. A. Cooper, J. K. Curtis, K. L. Puestow, J. W. Gale*, and *O. O. Meyer* explained the symptoms and treatment of illnesses ranging from emotional disorders and cancer to poison ivy and the common cold. Using x-rays, slides, and models, the doctors showed the businessmen how to make longevity and leadership compatible.

Doctor Pisciotta Accepts New Position

Dr. Anthony V. Pisciotta, formerly of Boston, Mass., has taken over his duties as head of the hematology service at the Milwaukee County General Hospital and as instructor in medicine at Marquette University School of Medicine. He also will conduct a research program in leukemia under a grant by the Milwaukee division of the American Cancer Society.

The doctor is a graduate of Marquette and formerly was a resident at the County General Hos-

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pital. For the past year he has been studying diseases of the blood at the New England Center Hospital in Boston.

Doctor Lindert Receives Certification from Specialty Board

M. C. F. LINDERT

Dr. M. C. F. Lindert, assistant clinical professor of medicine at Marquette University, was recently certified as a specialist in gastroenterology by the American Board of Gastroenterology. In addition to his teaching duties, Doctor Lindert maintains a private practice. He is a diplomate of the American Board of Internal Medicine.

Canadian Physician Accepts Position in Milwaukee

Dr. Romeo de Grandpre of Burlington, Vt., was recently appointed as associate medical director of the Junior League Blood Center of Milwaukee. A 1946 graduate of the University of Montreal Medical School, the doctor has been on the research staff of the division of experimental medicine at the University of Vermont Medical School since 1950. In Milwaukee, Doctor de Grandpre will aid the present medical director of the blood center, *Dr. T. J. Greenwalt*, in administrative work, and later will do research work with Doctor Greenwalt.

Doctor Blount Returns from European Trip

Dr. W. P. Blount, Milwaukee orthopedic surgeon, recently returned from a two week visit in England, where he attended the Joint Congress of Orthopedic Associations of the English Speaking World at London University. He was program chairman of the 200 man American delegation.

Marquette to Offer New Course

Marquette University will offer a course in physical therapy for the first time this fall, according to *Dr. John S. Hirschboeck*, dean of the School of Medicine. The new curriculum will be a four year course, with the last two years spent in the Medical School with actual clinical training given by means of supervised internship in city institutions. Twenty students will be accepted each class year. The course was organized at the University in response to community demands and the need for such specialists.

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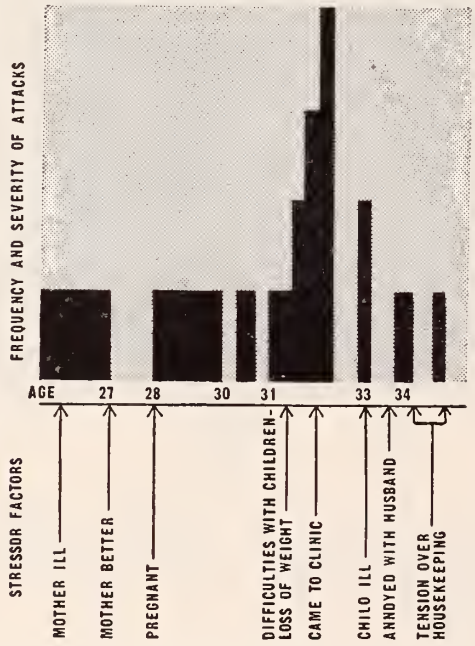

After: Relationship Between Life Stress And Symptoms — Stevenson, I.: G.P. *4*: 67 (Dec.) 1951

When emotions aroused by these stresses are not dissipated in appropriate biological behavior, heightened autonomic impulses beat against a "moored" physique.[1]

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* Dosage of each ingredient adjusted to the needs of the particular patient.

[1] *Cleghorn, R. A. and Graham, B. F.: Recent Progress in Hormone Research, Vol. IV, New York, Academic Press, Inc., 1949, p. 323.*

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O. G. Glesne, Beloit Municipal Hospital, Beloit.

L. E. Becher, Grant Community Hospital, Lancaster.

J. L. Guckien, 2417 West Brown Street, Milwaukee.

E. S. Huston, 2825 North Marietta Avenue, Milwaukee.

Elaine M. Thomas, City Health Department, City Hall, Milwaukee.

Changes in Address

Mabel E. Tuchscherer, Milwaukee, to 617 Locust Street, Anaconda, Montana.

P. K. Odland, Milwaukee, to 1108 Milwaukee Avenue, Janesville.

G. T. Hoffmann, Madison, to Surgical Unit, John Sealy Hospital, Galveston, Texas.

D. H. Engels, Fond du Lac, to 1624 Charlestown Avenue, Huntington, West Virginia.

J. S. Feurig, Milwaukee, to University Hospitals, University of Missouri, Columbia, Missouri.

R. P. Still, Wausau, to West Suburban Hospital, Oak Park, Illinois.

W. F. Mazzitello, Milwaukee, to Apartment 204, 2037 Yorkshire Avenue, St. Paul, Minnesota.

R. J. Krill, Muskego, to 1823 North 71st Street, Wauwatosa.

D. J. Malloy, Milwaukee, to Veterans Hospital, Hines, Illinois.

R. H. Ware, Madison, to % Mrs. J. F. Lucas, 1733 Polk Street, Alexandria, Louisiana.

DEATHS

Dr. Victor H. Cremer, 56, Tomah physician for the past 22 years, died on July 28 at his home following an illness of several years duration.

Born December 27, 1895 in Cashton, he graduated from Marquette University School of Medicine in 1927 and served his internship at St. Mary's and Emergency Hospitals in Milwaukee. He established his practice in Tomah in 1929. He was in active private practice there until 1947 when he accepted a position with the Veterans Administration Hospital in Tomah. Because of the condition of his health, he retired on August 1, 1951.

Doctor Cremer is survived by his wife, a son, and a daughter.

Dr. Howard J. Kenney, 47, Delavan physician since 1931, died suddenly on July 20 at his home. He was born September 1, 1904 in South Beloit.

A 1930 graduate of Marquette University School of Medicine, the doctor served his internship, was junior house physician from 1929 to 1930, and was senior house physician from 1930 to 1931 at Milwaukee County Hospital prior to establishing his practice as an associate with the Delavan Clinic. He was a member of the executive staff at Lakeland Hospital, had served as medical director of civilian

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defense in Walworth County, and was physician for the Red Cross in Delavan.

In 1950 Doctor Kenney was honored by his election to the rank of Certified Fellow in the International College of Surgeons. He was a former president of the Walworth County Medical Society, and also held membership in the State Medical Society and the American Medical Association.

Survivors include his wife, two sons, and a daughter.

Dr. Malcolm P. Andrews, 73, Manitowoc eye, ear, nose and throat specialist for 33 years, died suddenly on July 29.

The doctor was born at Lebanon, Ill. on April 1, 1879. He attended McKendree College of Illinois and later transferred to the University of Illinois where he was graduated from the medical school of the university in 1905. He practiced at Abbotsford for five years, where he served as division surgeon of the Wisconsin Central Railroad. After leaving Abbotsford he returned to school and completed work to specialize in eye, ear, nose, and throat. He next located at Beloit for seven years prior to entering military service during World War I.

Upon his discharge from service, Doctor Andrews opened his office in Manitowoc in 1919. He left the city temporarily in 1946 to be resident physician at Florida State College for Women at Tallahassee, but the next year returned to Manitowoc to resume his practice.

He was a member of the American Academy of Ophthalmology and Laryngology, the Rochester Surgeons Club, the Oto-Ophthalmic Society of Milwaukee, the Radiological Society of North America, the Manitowoc County Medical Society, the State Medical Society, and the American Medical Association.

Survivors include his wife and a son, Dr. Edson Andrews of Tallahassee, Florida.

Dr. **Charles W. Baugh**, 70, former chief of staff and former chief of surgery at Deaconess Hospital, died on July 13 in a Milwaukee hospital following a short illness.

Born in Manitowoc County on July 1, 1882, the doctor was graduated in 1904 from the old Milwaukee Normal school, now Wisconsin State College, and in 1911 from the Wisconsin College of Physicians, now Marquette University School of Medicine. He joined the staff of Deaconess Hospital in 1915 and served as chief of surgery from 1934 to 1942 and as chief of staff from 1939 to 1941.

He retired from active practice in 1941 and at the time of his death was living in Menomonee Falls. He was a member of the Medical Society of Milwaukee County, the State Medical Society, and the American Medical Association.

He is survived by his wife and two daughters.

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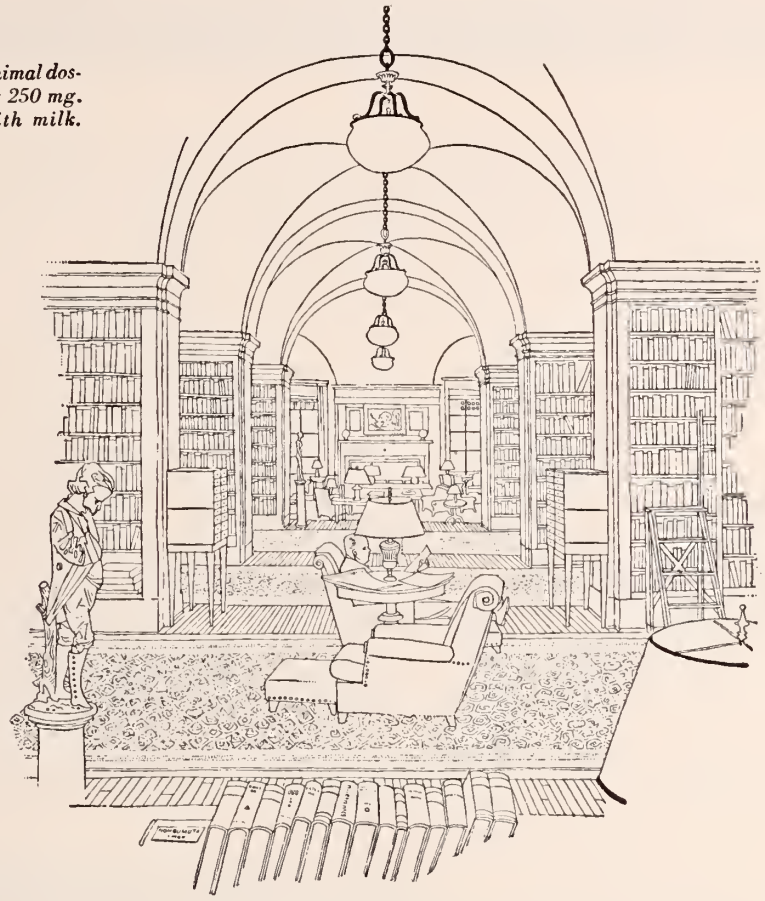

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THE JOURNAL BOOKSHELF

Handbook of Nutrition; A Symposium prepared under the auspices of the Council on Foods and Nutrition of the American Medical Association. Second Edition. New York, Philadelphia, Toronto, The Blakiston Company, 1951. Price $4.50.

This volume is a symposium prepared under the auspices of the Council on Foods and Nutrition of the American Medical Association. Its many contributors are all recognized leading authorities in nutrition and allied sciences. The subject matter included is more extensive than the title would suggest. There is a great deal of space given to purely biochemical and physiological matters.

The first edition appeared in 1943. Much has been added. The exigencies of the intervening war and its aftermath required intensification of research in these fields, with particular emphasis on physical and psychological changes under circumstances of unusual stress, such as starvation and the extremes of temperature and altitude. New investigative tools were developed which have contributed greatly to the field of nutrition. Foremost among these are isotope tracers and newer methods of chromotography. Investigation with these relatively recent instruments is extensively reported.

In general, this is an inexpensive and adequate source book on subjects related to nutritional requirements, intermediary metabolism, fluid therapy, etc., under normal and abnormal circumstances. Although there is much contained which would be of interest to the average general practitioner, the book would be most useful to the clinical investigator.—F. C. L.

A Bibliography of Infantile Paralysis, 1789–1949; With Selected Abstracts and Annotations. Prepared under direction of the National Foundation for Infantile Paralysis, Inc. Edited by Morris Fishbein, M. D., Editor, Excerpta Medica; and Ella Salmonsen, chief, medical department, John Crerar Library, Chicago; with Ludvig Hektoen, M. D., editor emeritus, Archives of Pathology. Second edition. Philadelphia, London, and Montreal, J. B. Lippincott Company, 1951.

This second edition of the abstracts and bibliography in the field of poliomyelitis continues along the same excellent plan as the first edition, with a well considered subject and author index. The earlier volume covered the literature from 1789–1944; the present one includes the earlier years with some 300 additional references and brings the literature up to 1950. The publication of inclusive pages in all the new citations in this edition will add appreciably to its usefulness. All persons interested in this or related diseases and the underlying problems will be indebted to the National Foundation for Infantile Paralysis for this publication.—P. F. C.

Handbook of Medical Management. By Milton Chatton, A. B., M. D., instructor in medicine, University of California Medical School, San Francisco; Sheldon Margen, A. B., M. D., clinical instructor in medicine, University of California Medical School, San Francisco; and Henry D. Brainerd, A. B., M. D., assistant clinical professor of medicine and pediatrics, University of California Medical School, San Francisco; assistant clinical professor of pediatrics, Stanford University School of Medicine; Physician in charge, isolation division, San Francisco Hospital. Second edition. Palo Alto, California, University Medical Publishers, 1951. Price $3.00.

This pocket-sized paper bound book contains 500 pages of terse comment on the management of a wide variety of medical conditions. It is aimed at the intern level of medical education and would be of value to practitioners as a convenient volume to carry in one's car or bag. Those portions to which

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1. Hutcheson, J. M.: Monagement of Cordiac Failure. *Virginio Med. Monthly*, 74:458, Oct., 1947.
2. Noth, P. H.: Pick's Disease: A Record of Eight Years' Treatment with Salyrgan, Ammonium Nitrate, and Abdominol Paracentesis. *Proc. Staff Meet. Moyo Clin.*, 12:513, Aug. 18, 1937.

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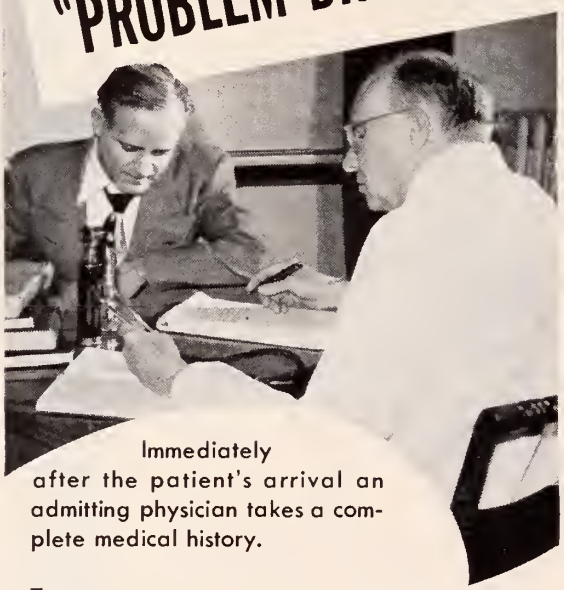

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I have given careful scrutiny are accurately and intelligently written. Of special interest to hospital house officers is the inclusion of code numbers from AMA's 1942 edition of "Standard Nomenclature of Diseases and Operations."

The book is recommended in spite of its flimsy binding. The reviewer feels the book is overpriced. —R. F. S.

Selling Industrial Hygiene. By Walter H. Poppe, Jr. Madison, Wisconsin, State Board of Health of Wisconsin, 1952. Price, $1.00.

This small booklet of 40 pages is most appropriate for demonstrating in condensed form many of the important aspects of industrial health. Mr. Poppe has chosen his examples to illustrate the significance of this field with telling effectiveness. A great deal of specific useable information is also condensed in the few pages.

There would seem to be a real need for greater awareness of the significance of this field to the health and well-being of a large proportion of the population in the United States. Industrial health, with its implications, has a magnitude which extends beyond that of any specialty in medicine. The need for such publications as that prepared by Walter H. Poppe, Jr., is very real. In my judgment, this small, lucidly written booklet represents a contribution of value.—J.W.B.

Eternal Eve; The History of Gynaecology and Obstetrics. By Harry Graham. Garden City, N. Y., Doubleday & Company, Inc., 1951. Price $10.00.

This volume is an interesting history of obstetrics and gynecology. The pageant of childbirth is portrayed by the author from the legends of primitive peoples and is traced through the slow change from mystic and magic concepts, from sorcery to science. The major chapters concern such well known contributors to the advances in the field as William Hunter, the Chamberlens, Oliver Wendell Holmes, Semmelweiss, Sims, and many others. The importance of the discovery of ether anesthesia and chloroform anesthesia are emphasized. The development of x-ray and radium for therapy and diagnosis take up much space and are described in a most interesting manner. The book will be both entertaining reading and serious history and biography for the layman as well as for the physician.—M.J.T.

The 1951 Year Book of Drug Therapy. Edited by Harry Beckman, M. D., director, departments of pharmacology, Marquette University Schools of Medicine and Dentistry; consulting physician, Milwaukee County General and Columbia Hospitals. Milwaukee, Wisconsin. Chicago, The Year Book Publishers, Inc., 1951.

The review of the 1950 volume of this year book has but recently (April 1952) appeared in this journal. An extensive itemization of the current number thus seems unnecessary. To indicate the directness with which the author attempts to keep the busy practitioner in contact with the most current therapeutic practices, it need only be noted that there is no preface—merely a two page table of contents—

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and the body of the book is begun on page 5! As with the two previous years' summarizations by Doctor Beckman, this third year book under his editorship would seem the most logical, expedient, and authoritative source for anyone in medical practice to get an over-all survey of therapeutic advancements in the past twelve months.—O. S. O.

Dynamic Psychiatry. By Louis S. London, M.D. Volume One. New York, Corinthian Publications, Inc., 1952. Price $2.00.

This book professes to be a survey of basic principles in dynamic psychiatry. To the author's mind these basic principles apparently revolve about an understanding of libido functioning. Most of the content of the book is an exposition of such theory. The assumption that basic principles can be conveyed through an understanding of libido theory is an extremely debatable one in beginning. Moreover, as this assumption has been implemented within the covers of this book, I am forced to conclude that it not only fails in this purpose but indeed is not even a coherent account of libido theory itself. This writer is one of the many in psychiatry who regrettably confuse obscurity with profundity, and useful knowledge with words. As such it is an outstanding example of this variety of thinking, but I am afraid will be of little value either practically or theoretically to either the general practitioner or practicing psychiatrist. The book is permeated with the author's unsubstantiated and exclusively subjective conclusions and is therefore not recommended.—R.R.

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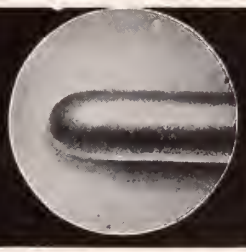

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WANTED: Physician interested in general practice in a small community in Wisconsin, and one who wishes to have at his disposal the latest in diagnostic facilities. Hospital staff appointment assured. Address replies to box No. 425 in care of the Journal.

PHYSICIAN WANTED to associate with a general practitioner in well established practice. Excellent hospital facilities. Address replies to box No. 426 in care of the Journal.

FOR SALE: General practice and equipment for 7 room office in prosperous dairy city of southern Wisconsin. This city of 5,000 has only 3 M.D.s in active practice. Residence available for sale or rental. Address replies to box No. 428 in care of the Journal.

FOR SALE: Complete set of surgical instruments in good condition. Besides common surgical instruments, stomach clamps, Rankin bowel clamp, cystoscope, external urethrotome, albie bone drill, esophageal dilator, many urethral dilators, retractors, many minor instruments, and a large glass surgical case are also available. Address replies to J. M. Scantleton, M. D., 114½ S. Water St., Sparta, Wis.

WANTED: Two physicians to buy a fully equipped clinic which is servicing an area containing 11,000 persons in north central Wisconsin. Liberal terms can be arranged. Address replies to box No. 436 in care of the Journal.

FOR SALE: General practice of physician and surgeon who died in April. Modern well equipped, air conditioned office in city of 5,000 with modern hospital. Liberal terms. Address replies to Mrs. W. J. Murawsky, Burlington, Wis.

PHYSICIAN WANTED: Assistant wanted in a general practice which includes a liberal amount of major surgery. This is in a well established modern office in a city of about 35,000 in central Wisconsin. Salary to start and early partnership hoped for. Address replies to No. 439 in care of the Journal.

WANTED: Psychiatrists or young doctors interested in psychiatry to work at Mendota State Hospital. These positions are permanent and under Civil Service, salary depends upon previous experience and training. Contact Dr. W. J. Urben, Superintendent, Madison 9, Wis.

FOR SALE: Four needles, containing over 12 mg. of radium each, recently assayed by the Bureau of Standards. Write to Mrs. W. M. Sonnenburg, 422 Bluff Ave., Sheboygan, Wis.

FOR SALE: Country practice with no competition. Only buy modern residence, with office and waiting room in residence—separate office entrance. Office in residence saves you office rent, phone, and secretary expense. Beautiful surroundings. Address replies to No. 440 in care of the Journal.

WANTED: Physician as associate, or to take over completely. Thriving practice in Cudahy (Milwaukee) Wis.; hospital connection, large office, well equipped. Write to Dr. H. J. Dvorak, 4718 W. Lisbon Ave., Milwaukee, Wis. Phone HI 4–7766.

WANTED: General practitioner for general practice in central Minnesota, population 30,000. New office building, good equipment. Permanent association desired. Address box 443 in care of the Journal.

E.E.N.T. WANTED: Physician wanted to take over a large, active, practice, established for 20 years. I have an offer from Calif. Clinic that is hard to turn down. Only the Wisconsin winters make possible this exceptional opportunity. Every condition here, including office space, is ideal. Address replies to box 446 in care of the Journal.

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FOR SALE: Hospital equipment (hospital discontinued). Stainless steel instrument table 20 x 48", large electric steam autoclave sterilizer, O. R. table, shadowless O. R. light, Sklar portable tonsil machine, numerous instruments, and bed pans, emesis basins, catheter trays, etc. Also all metal dressers. Address box 445 in care of the Journal.

PHYSICIAN WANTED, preferably out of internship, for general practice. Attractive salary and chance for partnership affiliation. New office building, good equipment, time off—good hunting and fishing. Address replies to box 421 in care of the Journal.

FOR SALE: Instruments and equipment of retiring eye, ear, nose, and throat physician who has been established in Wisconsin since 1916. Excellent opportunity for young man in city of 50,000. Address replies to box 449 in care of the Journal.

WANTED TO BUY: 100 MA x-ray and fluoroscopic unit such as the Picker Century; 2 hospital beds; electrocardiograph; infra-red light or baker; 2 treatment tables; set of book shelves; surgical instruments; and files. Address replies to box 450 in care of the Journal.

FOR SALE: Kelley–Koett Mobile X-Ray Unit, like new, and a slightly used Edin Cardiograph. Address replies to Downs X-Ray Company, 1004 N. Jackson St., Milwaukee 2, Wis.

FOR SALE: Eleven No. 58 Heidbrink Oxygen Tents, in good operating condition — make us an offer. Address replies to Mayo Clinic, Purchasing Department, Rochester, Minn.

FOR SALE: Light oak roll top desk with right side drawers, a swivel arm chair and matching straight back chair. Address replies to box 451 in care of the Journal.

WANTED: Physician as an associate to general practitioner in North Shore area of Milwaukee. Eventual full partnership possibilities. Modern, well equipped, air conditioned offices. Must be well trained. Excellent opportunity. Address replies to box 430 in care of the Journal.

PHYSICIAN WANTED: Resident or House for a 60 bed general surgical hospital; minimum salary $400 per month depending on qualifications and experience. Apply Doctors Hospital, 2711 West Wells Street, Milwaukee, Wisconsin.

SURGEON, well trained general and thoracic, capable, age 34, desires assistantship and association with busy general surgeon. Draft category IV, licensed in Wisconsin, Board eligible. Will do some general work, and am available immediately. Call Milwaukee, Hilltop 5–5881 or write to box 452 in care of the Journal.

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FICAN MEDICAL ASSOCIATION news notes

AMA news written especially for use in state medical journals

SEPTEMBER, 1952

Clinical Session Geared for GP

The sixth annual Clinical Session of the American Medical Association—meeting December 2–5 in Denver—will feature practical demonstrations on various phases of medicine of special educational value to the general practitioner. More than 60 scientific exhibits will provide the GP with a postgraduate course in such subjects as office anesthesia, cardiology, dermatology, endocrinology, gynecology, laboratory procedures, otolaryngology, pediatrics and proctology. Emphasis will be on diagnosis and treatment.

In addition to scientific papers presented by leading physicians from all over the United States, highlights of the meeting will include a large technical exhibit, surgical and clinical demonstrations on color television and motion pictures. All technical and scientific exhibits and scientific sessions will be held at Denver's recently-enlarged Municipal Auditorium.

Industrial Health Program for the GP

A program to interest general practitioners in industrial medicine recently was launched by the joint committee on education of the American Academy of General Practice and the Council on Industrial Health of the American Medical Association. The project proposes to encourage an understanding of industrial health problems by management and physicians and to develop an education program geared to the GP on both the undergraduate and postgraduate level.

Since more than 90 per cent of American industries employ less than 100 workers, the "family doctor" also must be educated on the part he can play in supervising and directing health and safety programs in small plants without interfering with his regular practice. The AMA's Council is prepared to assist local medical societies in carrying out educational programs designed to bring the employer and physician together by sponsoring local industrial health meetings.

Industrial Firms Purchase "Today's Health"

Large bulk orders of "Today's Health" magazine from several American industrial firms have been reported by the "Today's Health" Circulation Department as a result of continued promotion to industrial physicians. The Timken Roller Bearing Company of Canton, Ohio, for example, currently provides copies of "Today's Health" for the more than 1,300 supervisory personnel throughout its organization. The Chesapeake and Potomac Telephone Companies of Washington, D. C., have purchased about 250 subscriptions for chief operators in the Virginia, Maryland, West Virginia and District of Columbia area.

This year, the Pepsi-Cola Company is supplying "Today's Health" to a dozen of its locally-owned branch offices on a trial basis. If successful, the company will encourage all of its branch offices to subscribe for employees. Many firms are ordering from six to twelve copies for employee reading rooms.

AMA Prepares New Health Exhibit

Designed for lay audiences, a new portable exhibit entitled "Health—1952" will be available by mid-September from the AMA's Bureau of Exhibits for state and county medical societies. The exhibit presents an over-all picture of health conditions in the United States at the present time. The first panel, containing a large, colored modern adaptation of Sir Luke Fildes' painting, "The Doctor," emphasizes improved health conditions in the country today—showing that life expectancy has increased, tuberculosis, diphtheria and pneumonia deaths have skidded to an all-time low, mothers and babies have a much greater chance of surviving today. The second theme shows that Americans require less working time to pay for medical care today as compared with 15 years ago. Finally, the exhibit points out that today there is an easier way to pay for medical care—through voluntary health insurance.

The Bureau plans to revise and bring the exhibit up to date each year. The only cost involved to medical societies will be the shipping charges both ways.

Doctors Urged to Send in Poisoning Reports

The Committee on Pesticides of the American Medical Association currently is undertaking a country-wide toxicologic study of cases of poisoning resulting from the use of insecticides, rodenticides, fungicides, weed killers, fumigants, repellents and related types of chemicals used in agriculture and the home. This information will be used to expand its permanent file of such cases for use by physicians and allied medical personnel.

Since much of the Committee's information on pesticide poisoning has been compiled from unpublished isolated cases which were brought to its attention, the Committee appeals to physicians to submit records on cases of non-fatal and fatal poisonings from pesticides. The Committee points out that summary data on the pertinent facts of the poisonings and the circumstances of their occurrence would be sufficient in most instances. The Committee is functioning as a center for reporting this type of poisoning cases.

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List of Officers and Scheduled Meetings of County Medical Societies

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Barron-Washburn-Sawyer-Burnett	R. E. Lund Cumberland	Clive J. Strang Barron	Second Tuesday 7:30 p.m.
Brown-Kewaunee-Door	J. L. Ford 3030 S. Webster Green Bay	G. M. Shinners 409 E. Walnut Green Bay	Second Thursday*
Calumet	E. P. Larme New Holstein	L. W. Keller Brillion	
Chippewa	T. D. Foster Cornell	B. F. Rahn Cadott	Second Tuesday
Clark	K. F. Manz Neillsville	J. W. Koch Owen	
Columbia-Marquette-Adams	R. F. Inman Montello	E. G. Nafziger Oxford	Second Tuesday 7:00 p.m.
Crawford	O. E. Satter Prairie du Chien	H. L. Shapiro Prairie du Chien	
Dane	G. H. Ewell Jackson Clinic Madison	G. C. Hank 110 E. Main Madison	Second Tuesday
Dodge	C. L. Qualls Beaver Dam	R. E. Urbanek Beaver Dam	Last Thursday*
Douglas	C. T. Droege 1507 Tower Superior	R. T. Anderson 1507 Tower Superior	First Wednesday** Badger Room of the Hotel Superior
Eau Claire-Dunn-Pepin	W. G. Cameron 131 S. Barstow Eau Claire	H. E. Sorensen 314 E. Grand Eau Claire	Last Monday
Fond du Lac	R. W. Steube St. Agnes Hospital Fond du Lac	N. O. Becker 104 S. Main Fond du Lac	Fourth Thursday*
Forest	O. S. Tenley Wabeno	D. V. Moffet Crandon	
Grant	N. G. Rasmussen Montfort	H. W. Carey Lancaster	Last Thursday, March, June, Sept. and Nov.
Green	D. D. Ruehlman Monroe	L. G. Kindschi Monroe Clinic Monroe	
Green Lake-Waushara	Roy Hong Wild Rose	R. S. Pelton Markesan	Last Thursday, every other month starting in Jan

List of Officers and Scheduled Meetings of County Medical Societies—Continued

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Iowa	C. L. White Mineral Point	H. M. Walker Dodgeville	First Thursday following first Monday
Jefferson	E. A. Miller 133 Riverlawn Watertown	E. J. Netzow Lake Mills	Third Thursday*
Juneau	J. S. Hess Mauston	M. S. Tverberg Mauston	Second Tuesday Hess Clinic in Mauston
Kenosha	H. L. Schwartz 625 57th Kenosha	Helen A. Binnie 7609 25th Kenosha	First Thursday* Elks Club Kenosha
La Crosse	J. J. Satory 1707 Main La Crosse	D. M. Buchman 308 Newburg Bldg. La Crosse	Third Monday
Lafayette	D. J. Garland Shullsburg	N. A. McGreane Darlington	First Tuesday
Langlade	D. W. Dailey Elcho	F. H. Garbisch Antigo	Second Wednesday
Lincoln	L. J. Bayer Merrill	J. D. Millenbah Merrill	
Manitowoc	C. J. Radl Wood Block Manitowoc	W. C. Randolph 819 Hancock Manitowoc	Last Thursday
Marathon	D. M. Green Trust Bldg. Wausau	G. R. Hammes 529½ 3rd Wausau	
Marinette–Florence	J. M. Bell 1723½ Main Marinette	R. J. Rogers Oconto	Third Wednesday St. Joseph's Hospital
Milwaukee	N. J. Wegmann 2510 W. Capitol Milwaukee	W. T. Casper 2218 N. 3rd Mr. J. O. Kelley, Ex. Sec. 208 E. Wisconsin	Second Thursday
Monroe	C. E. Kozarek Tomah	J. S. Mubarak Tomah	Third Monday
Oconto	H. A. Aageson 1113 Main Oconto	G. R. Sandgren Suring	
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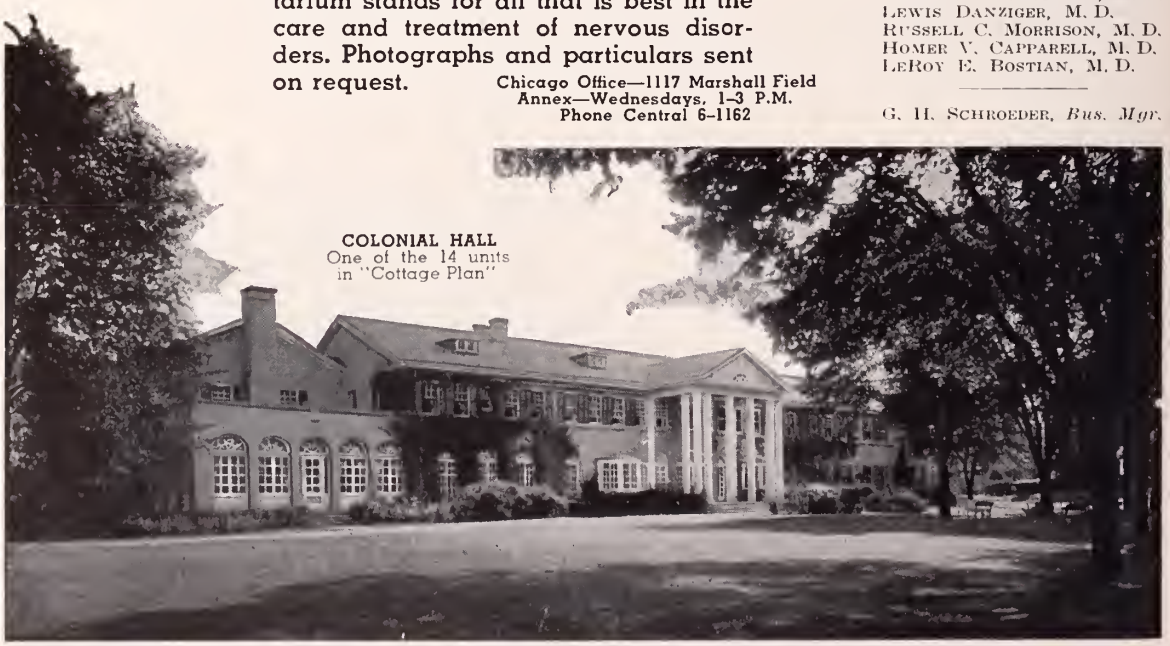

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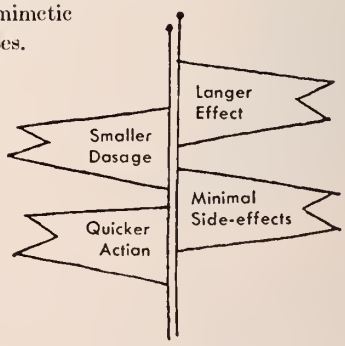

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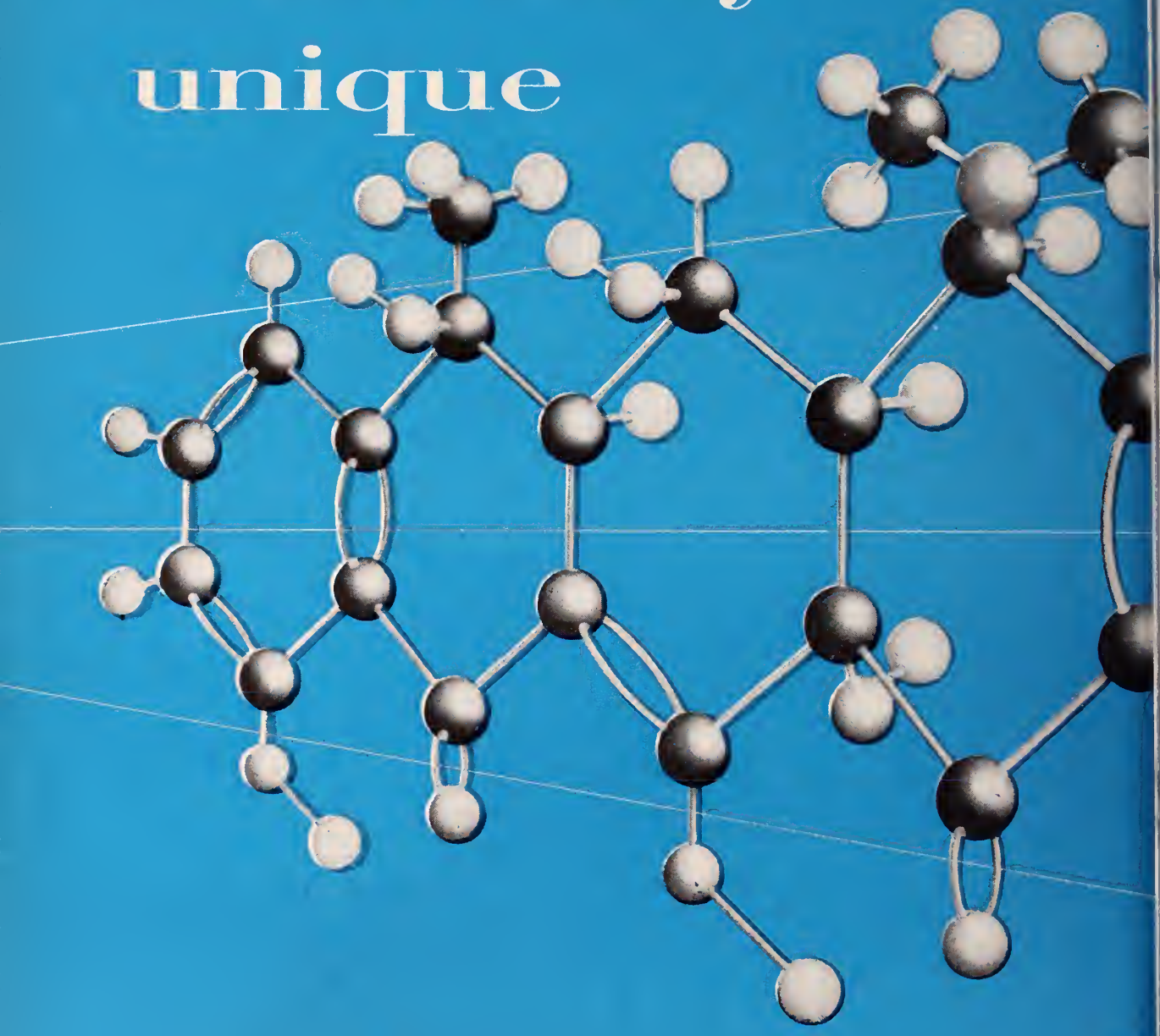

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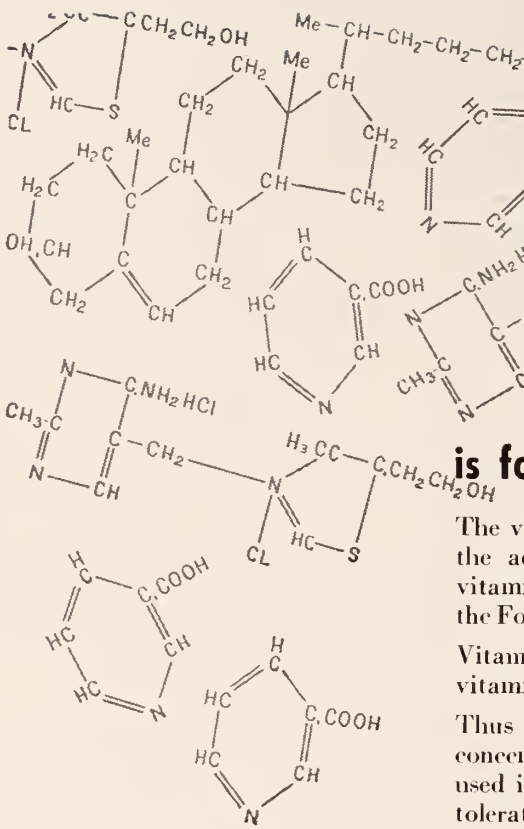

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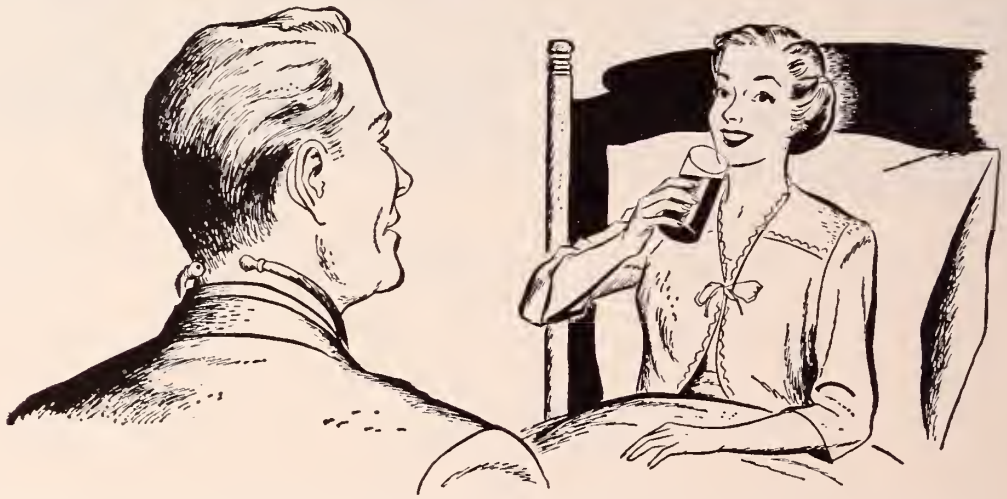

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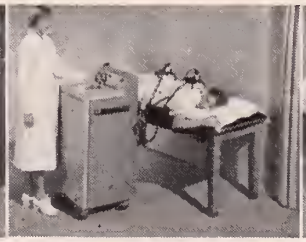

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Special Feature in Scientific Section

The scientific material of this issue is principally a discussion of problems in cardiology.

The first three articles, those of Drs. Miale, Gale and Rosenbaum, are from a symposium on diseases of the coronary arteries presented at the Annual Meeting of the State Medical Society in October, 1951. The others, on mitral valve surgery, were submitted as original contributions since then.

Cardiovascular disease is a front rank health matter and notable advances have been made, not only in the clinical phases but also in the basic physiologic and pathologic concepts. These are critically appraised. The roles of the electrocardiograph and of cardiac catheterization technics are assessed. New methods of treatment, medical and surgical, are examined.

We are fortunate in having all of this material available at one time. In commending it to our readers, we wish to express our sincere appreciation to the authors whose efforts have made the presentation possible.—R. S. BALDWIN, M.D., *Medical Editor.*

The Variety Club Heart Center

Recent advances in cardiac surgery have added to the diagnostic responsibilities of the internist. His surgical colleagues with their new technics are prepared to offer specific remedies for conditions formerly considered hopeless, provided the defects can be diagnosed with precision. To meet the demands for greater diagnostic accuracy, new methods have been developed.

The new methods, complicated and highly technical, require well trained and skillful teamwork.

This issue of the *Journal* contains reports on mitral valve surgery from Marquette University School of Medicine. The diagnostic studies were made by the cardiovascular section, whose personnel conduct the Variety Club Heart Center.

The services of this Center are available to all physicians of the state who have patients in need of cardiac catheterization studies for diagnosis of congenital heart defects, mitral stenosis, or certain other surgically remediable cardiovascular conditions. Inquiries should be addressed to The Cardiovascular Section, Marquette University School of Medicine.

Comments from the Wisconsin Press

"Ethics and the Tax Law"

"The American Medical Association has long held it unethical for a surgeon to split the fee he receives for an operation with the physician who recommended him to the patient.

"Such fee splitting does, however, occur and the bureau of internal revenue has now ruled that the surgeon may deduct what he pays to other doctors from his taxable income.

"Isn't this another argument for making federal tax returns open to public inspection, as state returns have been for many years? Nobody can now know whether a physician is observing the ethics of his profession in this and similar matters. Permitting inspection of all tax returns would enable a local medical society, or an individual, to uncover any unethical practice involving fees, just as it would enable other interested persons to check returns of other individuals for suspected deviations from the legal and moral codes.

"There has been no abuse under Wisconsin's open tax return law. On the other hand, much good has come from it. There is no reason to suppose that opening the federal tax returns would not have the same beneficial results."—MILWAUKEE JOURNAL, Sept. 13, 1952.

* * *

"Medical Schools Expand"

"It is to the credit of medical schools that without any lowering of standards they are providing steadily increasing facilities for the training of medical students.

"A report by the Council on Medical Education and Hospitals of the American Medical Association shows that more than 300 million dollars has been spent since the end of World War II in expansion of medical school facilities. There were 27,076 medical students enrolled in United States schools in 1951–52, as compared with 26,186 in the preceding year. That is an increase of 3.4 per cent. In the five years before the war, there was an annual average enrollment of 21,514 students. The present total represents an increase of more than 25 per cent since before the war.

"As a group, the medical schools today are better supported than at any time in history and they are conducting programs of education and research that far surpass both qualitatively and quantitatively any previous efforts. The American public will be pleased with this progress, for it provides assurance that the medical profession will be able to meet requirements."—SHEBOYGAN PRESS, Sept. 12, 1952.

* * *

"We Can Thank Doctors . . ."

"Medical science, surgical science and all of the great progress in drugs, x-rays, mechanical apparatus and other advancements in the great battle for health have won a stupendous victory in the last half century, by cutting the death rate in half.

"Unfortunately, the medical profession has been kicked around considerably by politicians and some others who think the profession has too much freedom and should be put under control on a nationalization basis and by some form of "socialized" medicine.

"But the ordinary citizen, who has benefited so much from the attainments and independence of the medical profession, can be glad that our physicians and researchers have their freedom and have used it so well for the good of their fellow man."—OSHKOSH DAILY NORTHWESTERN, Aug. 16, 1952.

* * *

"The Hazards of Fear"

"A Green Bay doctor who addressed a service club in Marinette said undue stress was placed on heart trouble. So much is said and written about heart ailments that a lot of people get panicky, he concluded. Emphasis can be overdone and another example, though remote from the subject, is the demand for eliminating turns and curves in highways. It has been brought out that motorists are more likely to be alert when they confront hazards than when they are driving on wide open, straight stretches. Maybe there is too much emphasis on eliminating hazards and not enough on good driving."—MARINETTE EAGLE-STAR, Aug. 29, 1952.

* * *

"Horror Programs on the Air"

"The Journal of the American Medical Association expresses concern lest the large number of TV 'crime and horror programs' may endanger the health of the nation's children.

". . . there is every reason why the possible damaging effect of these programs should be immediately and thoroughly studied by competent experts, as the Journal of the American Medical Association suggests."—MILWAUKEE JOURNAL, Sept. 8, 1952.

Pathologic Considerations in Myocardial Infarction*

By JOHN B. MIALE, M. D.
Marshfield

THE most significant progress made in recent years in the study of myocardial infarction has been along four lines: progress in electrocardiography, adaptation of injection technics to the study of coronary circulation, a rediscovery of the finer anatomical structure of the heart muscle, and, lastly, advances in surgery of coronary heart disease.

It is not the purpose of this paper to present a critical review of each of these developments, significant as they have been. I would like instead to concern myself with the normal and pathologic anatomy of heart muscle since it seems obvious that further illumination of cardiac physiology, both normal and pathological, more precision in electrocardiographic interpretation, and extension of the applications of cardiac surgery must ultimately be based on accurate anatomic studies.

From the anatomic standpoint, observations made by Vesalius in the 1500's and extended recently by numerous workers[1-5] have led to the concept that the heart is structurely composed of five fairly distinct muscle bundles, all of which in varying degrees make up the wall of the ventricles. Four of these bundles are of greatest importance, the right ventricle being composed of two distinct bundles and the left of various portions of at least four. As shown in figure 1, the right ventricle is composed chiefly of the deep sinospiral muscle with only a small contribution from the superficial bulbospiral muscle. The left ventricle, on the other hand, is made up of elements of the superficial bulbospiral, superficial sinospiral, deep bulbospiral, and the deep sinospiral, while the interventricular septum is composed either of superficial sinospiral, deep bulbospiral, and deep sinospiral or of superficial bulbospiral, deep bulbospiral, and deep sinospiral muscles, depending on whether we are considering the anterior or the posterior half. In general, the superficial muscles sweep down from an attachment around the aortic ring and the mitral ring down to the apex and then sweep up on the inside of the left ventricle forming the endocardial aspect of this chamber and also making up the anterior and posterior papillary muscles. The deep bundles, although they roughly follow a swirling arrangement, appear not to be split in this fashion but make up the deeper portions of the ventricular walls.

The existence of these muscle bundles is more than a matter of academic interest. There have been many reports[6-10] that in myocardial infarction the infarct is, in many cases, localized to one or more bundles and that even the wall of an aneurysmal formation in the ventricle is composed of separate layers corresponding to the muscles which originally form the wall at that point.[11-13] In the recent paper by Wartman and Souders,[10] a survey of 50 hearts showed that 25 infarcts in 21 hearts were each confined to a single muscle bundle, and that a total of 72 ventricular infarcts discovered in the 50 hearts all showed definite configurations which corresponded to the muscle bundles.

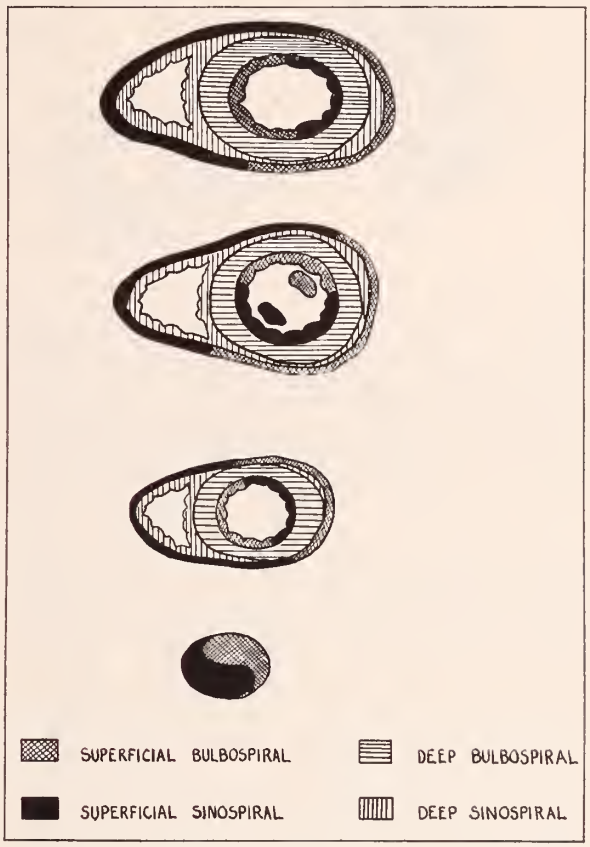

Fig. 1.—Schematic representation of the arrangement of the cardiac muscle bundles as seen in cross sections.

The experience in my own laboratory is very much the same. Figure 2 (C) shows a myocardial infarct in a 65 year old man which comparison with figure 1 and figure 2 (A, B) will show is limited almost entirely to the superficial bulbospiral muscle. Details of this and other cases will eventually be published elsewhere, but we have found this to be true when the heart is examined with its true anatomic structure in mind. Furthermore, by the use of injection technics, we have come to the conclusion that the distribution of the coronary arteries and their branches is not regional in the classic sense but rather that specific branches supply specific areas of specific muscle bundles.

* From the laboratories of St. Joseph's Hospital and the Marshfield Clinic, Marshfield, Wisconsin.

Presented as part of a symposium on coronary heart disease at the One Hundred and Tenth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1951.

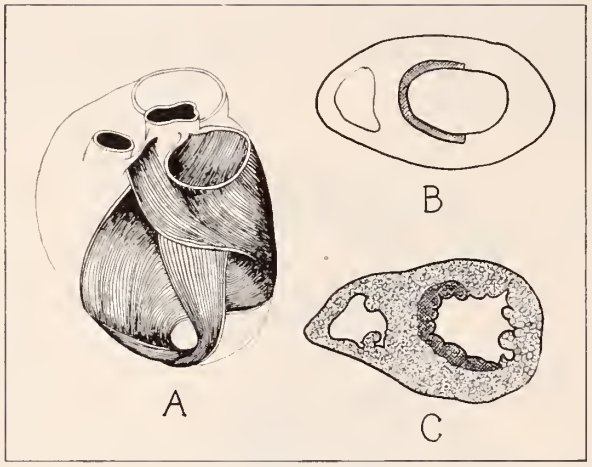

Fig. 2.—A. The superficial bulbospiral muscle arising from the conus tendon, pulmonary root, left trigonum fibrosum, and left auriculoventricular ring, forming the vortex at the ventricular tip, and swirling upward to form part of the subendocardial layer of the left ventricle. B. Schematic representation of the subendocardial portion of the superficial bulbospiral muscle. C. Distribution of a myocardial infarct in a 65 year old male, limited exclusively to one muscle bundle.

These anatomic considerations have important physiologic and pathologic implications. For example, rupture of the ventricular wall will not take place unless all three of the muscles composing the ventricular wall at that point are damaged. Likewise, rupture of the interventricular septum, a syndrome which is being diagnosed with increasing frequency during life, cannot take place unless the same conditions exist. Another observation of great importance is that mural thrombosis occurs only when the superficial muscles are involved and, therefore, the underlying endocardium is damaged. When the subepicardial portions are infarcted, a friction rub is to be expected and not until then. These are some of the more important findings previously described and supported by our own cases and indicate the basic importance of appreciating this aspect of myocardial pathology.

Much work remains to be done, of course, and it is not my purpose at this time to present definitive data on this very important subject. Rather, I would make a strong plea for a more physiologic approach to the study of myocardial infarction on the part of the pathologist and for close cooperation between pathologist and clinician in working out the pathologic physiology which is involved. The electrocardiographic findings, for example, should be correlated with specific muscle bundle distribution of infarcted areas if possible, as has been done recently[14] for subendocardial infarcts. The problem of collateral circulation is an extremely important one which still requires much study, and this obviously has an important application in surgery directed to restoring a damaged coronary circulation.

This brief summary of the problem has perhaps asked more questions than have been answered. However, with the problems well defined, the answers should be forthcoming and cooperative studies between pathologist and cardiologist will, I am sure, result in more definitive knowledge of this very important disease state.

Marshfield Clinic.

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POSTGRADUATE COURSE ON DISEASES OF THE CHEST ANNOUNCED

The Fifth Annual Postgraduate Course on the Recent Advances in Diseases of the Chest, sponsored by the Council on Postgraduate Medical Education and the New York State Chapter of the American College of Chest Physicians, will be presented at the Hotel New Yorker, New York City, November 10–14, 1952.

This course is open to all physicians, but the registration will be limited. Tuition fee is $50.00; applications will be accepted in the order in which they are received.

Surgical Treatment of Coronary Artery Insufficiency*

By JOSEPH W. GALE, M. D. and WILLIAM P. YOUNG, M. D.
Madison

SURGEONS have long considered the desirability of bringing a new blood supply to the ischemic myocardium resulting from coronary artery insufficiency. There were no encouraging results, however, until 1935 when Beck[1] reported suturing the pectoral muscle to the heart. About this time O'Shaughnessy[2] also reported promising results from applying omental grafts to the myocardium, but this study has not been continued since his death in the battle of Dunkirk.

Lezius[3] used the lung as the source of a graft of vascular tissue to the heart muscle. Anastomosis between the arterial bed of the lung, grafted upon the heart and the coronary arteries, has been studied recently by Carter.[4] A lung was sutured about a window in the pericardium after a paste of finely divided sterile asbestos powder had been applied to the epicardium and the lung.

In sacrificed dogs, India ink which had been mixed with citrated blood and perfused through the pulmonary arteries at 30 to 40 mm. of mercury for 30 minutes appeared in the superficial myocardium. Twenty-three normal dogs had suffered a 48 per cent mortality following ligation of the anterior descending branch of the left coronary artery. Nineteen grafted dogs had a 21 per cent mortality following the same ligation, and the surviving dogs in this latter group were found to have a deeper collateral circulation than the dogs without ischemia. Two of three humans having this procedure were improved; a third died of infection during the immediate postoperative period.

The direction and volume of blood flow may well be questioned. How long the collateral circulation will remain has not been determined and if it is through capillaries in granulation tissue, it may be expected to be temporary. It can probably be assumed that the degree of oxygenation of blood supplied from the lung would be adequate, as venous blood has a 60 to 70 per cent oxygen tension and fully oxygenated blood may be withdrawn from a catheter within small divisions of the pulmonary artery.

Thompson[5] made use of talc to form adhesions between the pericardium and epicardium (cardiopericardiopexy) to bring a new blood supply to the ischemic heart muscle. He placed talc in the pericardial sac to produce the adhesions. In discussing Vineberg's paper[20] he reported that this procedure had been done on 52 patients with a mortality rate of 12 per cent. Eighty-five per cent of the patients alive 1 to 15 years after the procedure were improved. Twenty per cent were considered normal. There was no tendency to the formation of a constrictive pericarditis.

Fauteux[6,7] approached the problem in 1940 by interrupting the nerve supply to the vessels of the myocardium and in 1946 by coronary sinus ligation and also anastomosis of the internal mammary artery with the coronary sinus.

Beck,[8–13] in addition to using pectoral muscle grafts and producing adhesions between the myocardium and the chest wall, has made an extensive study of cardiac vein ligation and arterilization of the coronary venous system. Using dogs, he anastomosed the proximal end of the divided left common carotid artery to the previously ligated coronary sinus. Ten dogs survived with open shunts; these then had ligation of the anterior descending branch of the left coronary artery with two delayed deaths in contrast to a 70 per cent mortality and massive infarcts in survivals, when the ligation was carried out in normal dogs.

Later with McAllister,[14] Beck used free artery and vein grafts between the thoracic aorta and the coronary sinus. The coronary sinus was ligated at an earlier stage so the walls would thicken. A stoma more than 4 mm. in diameter in the aorta caused the heart to fail. In 99 operations, 16 dogs were obtained with temporarily open grafts. (Three dogs were tried with a one stage procedure, but the blood would not flow and clots formed in the grafts.) Dogs that survived the shunt had engorged myocardia. Just ligating the sinus caused this engorgement. Sclerosing of the intima of the veins followed the production of the shunt. They hoped that larger human hearts with lowered blood supply would tolerate the procedure; but the procedure was done on two humans, both of whom were autopsied, and the myocardium of each was found to be engorged. They then wondered if the coronary sinus needed to be occluded and if so, how much? Ten dogs with the anastomosis done and the sinus open had the anterior descending branch of the left coronary artery ligated. There were four delayed deaths in this group. Then partial ligation of the sinus was carried out with the anastomosis. A suture was tied around the sinus over a 3 mm. probe (the anastomoses were usually 3.4 to 4 mm. in diameter). Ten dogs in this group had the anterior descending branch of the left coronary artery ligated two to four weeks later with only one death.

Vineberg[15–20] is using a method which may prove to be the best means as yet developed for the

*From the Department of Surgery, University of Wisconsin Medical School and State of Wisconsin General Hospital.

Presented as part of a symposium on coronary heart disease at the One Hundred and Tenth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1951.

surgical treatment of coronary artery insufficiency. He implants the left internal mammary artery into the left ventricular myocardium. He dissects the internal mammary artery from the chest wall, pulls it through a tunnel made in the myocardium of the left ventricle, secures the end with a single suture, but allows the vessel to ooze from the sixth intercostal artery opening which is at the end which extends beyond the tunnel. In dogs, the anastomosis of the transplanted vessel with the coronary artery can be proven by injection studies using radiographs, plastic casts, and serial sections.

Glen,[21] using dogs, verified the formation of new vessels connecting the transplanted vessel with those in the myocardium but believes the new vessels are similar to those in granulation tissue where they diminish, fibrose, and disappear. He is continuing long term studies, however. Vineberg has found several controllable factors to influence the per cent of anastomosis. The shorter the length of the artery freed the greater the per cent of anastomosis. The deeper the vessel is implanted the greater the per cent of anastomosis. More dogs developed anastomosis if heparin was used immediately postoperatively. The apex of the heart is the ideal location for this implantation as end arteries for both the left and right coronaries are located here and these tend to escape coronary sclerosis. The deeper arterioles most frequently escape sclerosis. It is probable that the ischemia present in human angina would stimulate anastomosis as partial occlusion of the anterior descending branch of the left coronary artery at the time of transplantation in dogs favored anastomosis of the transplanted vessel with the coronary artery. With these favorable conditions nearly 100 per cent of the transplants developed anastomosis with the coronary artery. Seventy-five per cent of dogs with transplants survived ligation of the anterior descending branch of the left coronary artery, in contrast to only 10 per cent survival of normal dogs having this artery ligation. The anastomoses have been proved to persist in dogs for 58 weeks.

Experimental coronary insufficiency has been produced in dogs by wrapping the first part of the anterior descending branch of the left coronary artery with a sclerosing cellophane. After four months the exercise tolerance in these dogs was reduced to less than two minutes on a treadmill in contrast to a normal exercise tolerance averaging seven minutes on a treadmill. Then four months after implanting the internal mammary artery into the left ventricular myocardium, the exercise tolerance in these animals returned to seven minutes on the treadmill. Only one of five dogs having the experimentally produced coronary insufficiency for eight months, but not having the internal mammary artery transplanted, had an increase in exercise tolerance. The others either showed a decrease or stayed the same as they were at the fifth month.

Vineberg reported in 1951 on four human cases of coronary artery sclerosis with angina on whom he had operated. The first died 62 hours after the surgery of a new coronary thrombus. This patient had low blood pressure during the procedure. In cases done since that one, special efforts have been successful in maintaining a satisfactory blood pressure. The second case was working and well. The third was improved, and the fourth was only two months postoperative.

The internal mammary is especially suited for use in this transplantation because it is easily accessible surgically, arises close to the aorta and carries a high blood pressure, has branches which insure flow of blood through the vessel, supplies no vital organ, and has proved to be free of arteriosclerosis in cases of coronary disease.

This problem of supplementing the blood supply to the myocardium is still in the investigative stage. The inability to give an accurate prognosis in any given case of coronary insufficiency makes it impossible to evaluate a procedure used on an occasional human. Long term studies are necessary, including the use of experimental animals, to determine the extent of function of the supplementary arterial channels after all granulation tissue has been replaced by scar tissue and degenerative changes have had a chance to develop in the new blood supply.

(J.W.G.) State of Wisconsin General Hospital.

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WISCONSIN TRUDEAU SOCIETY TO MEET IN MADISON

The Veterans Administration hospital in Madison will be the site of the fall meeting of the Wisconsin Trudeau Society, October 24 and 25.

Dr. Nicholas D'Esopo, medical director of the Sunmount, New York Veterans Administration Hospital will highlight the Friday afternoon program with an address on "The Present Status of Chemotherapy in Pulmonary Tuberculosis."

Featured in the Saturday morning session will be Reginald H. Smart, M.D., assistant clinical professor of medicine at the University of Southern California. His talk will be on "The Use of Intermittent Positive Pressure in the Treatment of Emphysema and Associated Chronic Pulmonary Diseases."

POSTGRADUATE CLINIC ON HEART DISEASE ANNOUNCED

Dr. Ovid O. Meyer, chairman of the postgraduate education committee of the Wisconsin Heart Association, announces a postgraduate clinic on heart disease for Wisconsin doctors.

The Faculty: Paul D. White, M. D., Consultant in Medicine, Massachusetts General Hospital, Boston, Mass.; Executive Director, The National Advisory Heart Council.
Alfred Blaloch, M. D., Professor of Surgery and Director of the Department of Surgery, Johns Hopkins University School of Medicine, and Surgeon in Chief, Johns Hopkins Hospital, Baltimore, Maryland.

The Time: Clinics will be held at the Marquette University School of Medicine in Milwaukee on Wednesday, October 22, and at the University of Wisconsin Medical School Auditorium in Madison on Thursday, October 23.

Description: Doctors White and Blaloch will conduct clinics in the afternoon on subjects furnished to them at the two medical schools. Each will give a formal presentation in the evening.
The title of Doctor White's talk in Milwaukee will be "Coronary Heart Disease," and his topic in Madison will be "Hypertensive Heart Disease." The doctor will also address the Milwaukee Academy of Medicine on October 21. He has chosen "Three Medical Eras" as his subject for this occasion.
The title of Doctor Blaloch's presentation will be "The Surgical Treatment of Certain Types of Cardiovascular Disorders."

These clinics are made possible through a special grant from the Wisconsin Heart Association and no fee will be charged. All members of the medical profession in Wisconsin are welcome.

LIBRARY OF THE

Treatment of Coronary Artery Disease*

By FRANCIS F. ROSENBAUM
Milwaukee

I PROPOSE in my contribution to this symposium to touch upon a few of the points which seem of practical importance in the treatment of angina pectoris and myocardial infarction.

The treatment of angina pectoris consists primarily of measures which will relieve the patient's distress. These measures may be prophylactic and anticipatory on one hand, or they may be for actual relief of pain, if it cannot be prevented. At the present time there is relatively little that we can do to alter the underlying pathologic changes in the coronary arteries once those abnormalities have made their appearance.

The diet taken by a patient with coronary artery disease is of importance. The patient who is overweight should be placed on a reduction program and encouraged to follow it until his weight has reached a normal level. This measure reduces the burden which the heart must bear and often is effective in reducing accompanying hypertension. Foods which cause indigestion and gastric distress should be avoided. The patient should never eat large meals or take large volumes of liquids at one time which produce a feeling of fullness.

The place that ingested cholesterol plays in the production or aggravation of arteriosclerosis is still to be determined finally.[1,2] Blumgart, Freedberg, and Kurland[3] have recently reported concerning 8 young patients with rheumatic heart disease for whom total thyroidectomy was done for relief of intractable congestive heart failure. At autopsy three to eleven years after total thyroidectomy, with production of pronounced hypothyroidism and hypercholesterolemia, only minimal or no coronary arteriosclerosis was found in these individuals. This observation would seem to suggest that a sustained high level of cholesterol in the blood does not by itself lead to the development of arteriosclerosis. In any event, it must be stated that at this time the hiatus in our knowledge of the relation between the cholesterol ingested in the diet and that deposited in the coronary arteries has not been bridged.

The various xanthine preparations, especially the different salts of theophylline and theobromine which are used so widely by all of us, merit a trial in any patient with angina pectoris. If one of them is ineffective, another should be tried. A combination of a xanthine preparation with some barbiturate often serves to relieve anxiety and tension sufficiently to contribute to the benefit of the patient. If for no other purpose, the necessity of taking a tablet at regular intervals three or four times daily serves to remind the patient that he has an important disorder with which he must learn to live and which requires that he follow a certain definite regime.

Khellin (visammin) is a di-methoxy–methyl–furano-chromome derived from an eastern Mediterranean plant known as Ammi visnaga. It is said to relax visceral smooth muscle by direct action on the muscle fibre. Although there have been some favorable reports[4] and it seems worth a trial in any patient with troublesome angina pectoris, I have not found many patients who have been much relieved by it and several for whom it has been prescribed have been rather distressed by its side effects. Atropine and its derivatives are not used as widely as they might be in patients with cardiac pain. Tincture of belladonna in full dosage is often of considerable help, and this is particularly true if the patient also has chronic cholecystitis or certain chronic gastrointestinal disturbances.

Nitroglycerine is a drug of great value in the treatment of angina pectoris, and yet we often must urge the patient to use it.[5] Unfortunately too many patients have the impression that there is something habituating about this drug, or they are fearful that if they use it there may be a time a few months or years hence when the need is greater and the nitroglycerine will no longer be effective. It is my belief that if nitroglycerine is really effective in any individual it will always be so, and if the medication fails, it does so because the underlying disorder has grown worse. In many instances the patient can be advised to use nitroglycerine prophylactically, that is, he can use it before he performs an effort which he knows is likely to produce pain. However, some judgement must be exercised in this regard lest the patient attempt a considerably greater effort than he should really undertake. When nitroglycerine is used in doses of 0.3 mg. (gr. 1/200), the patient usually has relief from his pain without uncomfortable aching and throbbing developing in the head which is often a disagreeable side effect of larger doses.

Amyl nitrite or an octyl nitrite inhaler may be used in much the same way as nitroglycerine, but they are not as convenient or agreeable to use. Recently a long acting nitrate preparation, pentaerythritol tetranitrate has been advanced as having a long acting coronary vasodilator effect lasting for four or five hours.[6] General experience with this preparation is limited, but initial reports have been encouraging.

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*From Department of Medicine, Marquette University School of Medicine.

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Decisions regarding smoking by patients with coronary artery disease are always difficult. There is no unanimity of opinion among various investigators in this field. There is some evidence that smoking has no effects in patients with heart disease which are significantly different from those in persons with normal hearts.[7] However, if there is any suggestion from the clinical history that the patient has more distress during or after smoking, I believe he should give it up. Occasionally a patient will be encountered who will have significant electrocardiographic abnormalities demonstrable during smoking, even though there is no cardiac pain at the same time.[8] Such patients are a minority, but they should stop smoking completely. The advice of the physician to the cardiac patient regarding smoking must be individualized, but actually it is my experience that the majority of patients will not follow the doctor's recommendations.

Recent studies suggest that alcohol is not as beneficial in coronary artery disease as many of us have hoped and believed.[9] These studies have been concerned with the observation that patients put through an exercise or provocative test did not get the same protection against the development of abnormal electrocardiograms when they were given one or two ounces of whiskey as when they were given 0.4 mg. (1/150 gr.) of glyceryl trinitrate before the test. However, we often see patients whose cardiac pain is unrelieved by nitroglycerine and yet who become comfortable promptly after taking one-half to one ounce of a concentrated alcoholic beverage such as whiskey or brandy. Russek and his associates[9] suggest that this type of response is due to a rapid acting sedative effect of the alcohol increasing the threshold for pain and promoting a sense of well being, but that it does not result from any coronary vasodilatory action. The use of alcoholic beverages is another matter which must be individualized. If a patient is permitted to take alcohol, he should be cautioned to avoid taking it in such quantities that his barriers are down and he is inclined to undertake more physical activity than he should. If alcoholic beverages are taken, I believe they should be in the more concentrated forms and that carbonated beverages should be avoided because of the gastric distention which they may produce.

The patient with angina pectoris should be studied very carefully from the point of view of his general health in order to discover any abnormality which may be aggravating the cardiac condition. Patients with angina pectoris often are found to have chronic cholecystitis. When the latter is recognized and properly managed, the cardiac pain will often be remarkably relieved. This same approach holds true for other serious disorders such as chronic anemia, some gastrointestinal disease, or diabetes mellitus.

Any patient who has intractable angina pectoris should at least be considered a candidate for radioactive iodine treatment. This is, of course, particularly true if there is any suggestion of hyperthyroidism, but even in euthyroid patients whose discomfort is truly intractable and totally incapacitating, it has been found that the patient can be made more comfortable or even partially rehabilitated by producing moderate hypothyroidism with radioactive iodine (I^{131}).[3] This is the same approach employed at one time with total ablation of the thyroid gland and at another with the thiourea drugs. Blumgart and his associates recommend that this treatment be used only if the basal metabolic rate is above minus 15, if the cardiac condition has been quite stable over a period of one year, and if the patient is inclined to be tense and overactive. At the present time our experience with this technic is somewhat limited and the dosage is difficult to estimate. In this same group of patients, sympathectomy may sometimes be necessary for relief of almost unbearable distress, but this measure is indicated for only a small percentage of the patients with angina pectoris.

Finally, I believe it should be emphasized that a patient with angina pectoris whose pain is changing in character, that is, is becoming more frequent, more severe, appearing on lesser exertion, or occurring at rest, may be having the premonitory manifestations of a myocardial infarction.[10] The activity of such a patient should be sharply curtailed until the situation becomes stabilized once more. It is usually wise to confine these patients to their homes or to a single room and admission to the hospital is frequently the wisest course to follow in order to prevent more serious trouble. If these steps are taken, myocardial infarction may often be prevented or myocardial injury at least kept to a minimum.

In myocardial infarction the immediate problem is relief of pain. Morphine is the drug of choice in this respect. If the patient is not relieved of pain by two doses of morphine sulfate, 15 mg. (gr. ¼) each, hypodermically, pantopon in a dose of 20 mg. (gr. 1/3) diluted in 10 cc. of normal saline or distilled water given intravenously will usually be effective. This solution should be given very slowly intravenously, and the injection discontinued the instant that the patient has relief from pain. For the patient who has frequent recurrences of distress during the first few days after the severe pain of myocardial infarction has been relieved, hypodermic injections of Demerol, Dilaudid, or Pantopon at regular three or four hour intervals will often anticipate the return of pain and keep the patient comfortable. Persistent pain associated with myocardial infarction may also be relieved in some patients with aminophyllin given intravenously in 100 to 200 cc. of glucose, administered carefully over a period of 30 minutes. Oxygen is also helpful in relieving the pain of myocardial infarction and preventing recurrences of distress during the early phases of recovery.

The patient with a myocardial infarction must rest until his lesion has healed and grown firm enough to withstand the stress imposed upon it by strenuous movement and ambulation. Recent obser-

vations by Benton, Brown, and Rusk[11] indicate that the patient actually expends less energy when he uses a bedside commode than when he uses a bedpan. I believe that, except in rare instances, a patient may be assisted out of bed, onto a commode, and then back to bed with less difficulty, more comfort, and better bowel function than he will have if he uses a bedpan. It is always important to caution patients with acute myocardial infarction against the Valsalva maneuver, that is, straining down against a closed glottis, during micturition or defecation.

The anticoagulants have seemed to reduce the incidence of thromboembolic complications in patients with acute myocardial infarction.[12] They should not be used unless frequent reliable determinations of the prothrombin time can be made. The anticoagulant drugs should not be used in any patient with chronic hepatic or renal disease or any gastrointestinal lesion which is inclined to bleed.

425 East Wisconsin Avenue.

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DISCUSSION OF THE PAPERS OF DOCTORS MIALE, GALE AND ROSENBAUM

DR. F. W. MADISON: We are all grateful to Doctor Rosenbaum for calling our attention to the fact that one more score has been marked up against the deadly bedpan. It is entirely possible that by the time some of us get on to our coronaries the commode will be in order.

Doctor Rosenbaum, how much time is required for healing of myocardial infarction and how much time is required to prepare the patient for activity afterwards? There is a great deal of difference of opinion on that particular point.

DOCTOR ROSENBAUM: I believe that a great deal depends upon the size of the individual infarction and the nature of the accompanying pathology. Studies carried out by Mallory, White, and Salcedo-Salgar[13] several years ago indicated that small infarcts are almost completely healed after five weeks and large infarcts are completely healed or undergo no further discernible change after two months. Consequently, small infarcts which are not associated with shock, marked leukocytosis, or striking elevation of the sedimentation rate probably heal relatively quickly and permit ambulation within one month. Larger infarcts require a longer period of restriction of activity. It is my present practice to keep the patient with an infarct of average size in bed, except for permission to use a commode, for four weeks. At the end of that time he is permitted to dangle his legs, then to sit in a chair, then to walk in his room, and finally in the corridors of the hospital so that when he leaves the hospital five and one-half to six weeks after the onset, he is able to go to the bathroom, to be up and about in his room, to eat at the table, and to do many of the things which relieve the load of nursing which is otherwise imposed upon the family. I have treated patients with myocardial infarction without putting them to bed at all, and I have also kept patients in bed for as long as two or three months if they were very sick or had a complicated course.

DOCTOR MIALE: I agree with this statement as to the time of healing of the given area of the myocardium. I think that there are a great many other factors that have to be considered. The amount and extent of the collateral circulation is probably a greater governing factor than the actual local tissue changes that take place in an area of infarction. In some of the old hearts with coronary sclerosis and in which well established collateral circulation is found, the patients need less time at bed rest. It takes about one month for a given point in a necrotic myocardium to reach its maximum strength.

DOCTOR ROSENBAUM: At the very outset the individual patient with myocardial infarction must be evaluated carefully. We have all seen young

individuals without antecedent angina pectoris who have had a myocardial infarct and have not done nearly so well as older patients who have a myocardial infarct after a long history of cardiac pain. The well developed collateral circulation in the latter group is apparently a factor in their better tolerance for the acute massive lesion.

Dr. F. D. Johnston: That is true and I would certainly agree with what Doctor Rosenbaum has said regarding treatment, particularly the use of the anticoagulants. The reduction of mortality is largely because of what we have accomplished in preventing thromboembolic phenomena secondary to the infarction. The formation perhaps of a mural thrombus within the ventricle will prevent its subsequent detachment and sending arterial emboli to various places. We are not as enthusiastic about the routine use of anticoagulants now as we were a year ago. As more data accumulates it appears that the experience of patients treated with anticoagulants is not significantly better than the others. Anticoagulants should not be given unless adequate laboratory facilities are available.

Question From The Floor: How do you handle the patient with a cardiac neurosis superimposed on coronary artery disease?

Doctor Rosenbaum: It is not easy to answer your question briefly. Every patient with heart disease, whatever its etiology, has certain fears and anxieties about himself. This is probably more true in patients with diseases of the heart than of any other organ. A patient with coronary artery disease is exposed repeatedly to the unhappy news of the death of his friends and acquaintances who suffered from the same disease which he has. This heightens his concern. I believe in the value of repeated strong reassurance and as prompt rehabilitation and return to useful work as the patient's physical condition will permit. If the patient is able to prove to himself that he can return to work and perform nearly all of the things he did prior to the infarction, cardiac neurosis will be kept to a minimum.

PROGRAM FOR ANNUAL DEARHOLT DAYS ANNOUNCED

Principal speakers for Dearholt Days in Milwaukee on November 10 and Madison on November 11 will be Max B. Lurie, M.D., associate professor of pathology at the Henry Phipps Institute in Philadelphia, and Richard L. Riley, M.D., associate professor of medicine at Johns Hopkins University, Baltimore.

An open meeting for physicians will be held at the Veterans Hospital, 2500 Lookout Terrace, Madison at 8 p.m. on Tuesday, November 11. Doctor Riley will speak on "Effects of Age Upon the Pulmonary Capillary Bed" and Doctor Lurie on "Constitutional Factors in Resistance to Infection: The Effect of Cortisone and ACTH in the Pathogenesis of Tuberculosis."

Afternoon sessions for physicians and medical school seniors will be held at the Marquette and University of Wisconsin medical schools on November 10 and 11 respectively. Doctor Lurie will speak on "The Nature of Genetic Resistance to Tuberculosis" and Doctor Riley on "Physiological Principles in the Management of Emphysema."

Dearholt Days are sponsored by the Wisconsin Trudeau Society, Dane County Medical Society, Veterans Administration, and Wisconsin Anti-Tuberculosis Association. They are held yearly in memory of Hoyt E. Dearholt, M.D., Wisconsin tuberculosis control leader.

Mitral Stenosis*

Surgical Treatment

By FORRESTER RAINE, M. D. and HENRY F. TWELMEYER, M. D.
Milwaukee

THE surgical treatment of mitral stenosis has proven to be practical. The rheumatic fever that caused the initial damage to the heart valve is often quiescent by the time healing has resulted in stenosis. The problem is purely a mechanical one. Blood from the left atrium must go through too small an orifice to reach the left ventricle and, as a result, there is increased pressure in the pulmonary veins, the pulmonary artery, and an increased load on the right heart. This leads to hypertrophy of the right ventricle, to distention and hypertension in the pulmonary artery, to engorgement of the lungs, and to enlargement of the left atrium. Activity increases all these abnormal tendencies because still more blood has to go through the same narrowed orifice to reach the systemic circulation.

The surgical approach to mitral stenosis has been envisioned for a good many years. Attempts were made to correct stenosis in 1923 by Cutler and Levine[1] who devised an instrument to punch out a side of the stenosed valve. These attempts to cure the stenosis produced so much regurgitation that the efficiency of the heart was as poor, if not poorer, than it was preoperatively and these patients succumbed. More recently, Bailey[2] in Philadelphia and Harkins[3] in Boston have devised very similar attacks upon the stenotic valve which would relieve the stenosis without creating an undue amount of regurgitation. This can be accomplished from a mechanical standpoint by re-opening the stenosed valve in its two commissures, preserving the valve leaves.

The most important valve leaf is the anteromedial one for it forms one wall of the ventricular outflow tract along which blood flows to the aorta. An opening which does not close completely in systole at the medial commissure is far more dangerous than the same sized one at the lateral commissure. The intraventricular pressure is less as the blood stream flows past the lateral end of the valve but, when it reaches the medial commissure, pressures are up to full systolic pressure and a small opening permits a large amount of regurgitation. Openings in the valve which do not close completely in the lateral commissure produce far less actual regurgitation of blood since the main force of the ventricular stream is not exerted at this point.

Whether the openings in each commissure are made with the finger, as advocated by Harkins,[3] or with a knife, as advocated by Bailey,[2] seems to be of little importance so long as the valve leaves are not injured. From a practical standpoint, most calcified and many uncalcified valves will open directly in the commissure by finger pressure without the use of the knife. Some must be cut if the tear is to be in the commissure and not across one of the leaves.

This theoretic concept of the surgical attack on the stenosed mitral valve has proven to be practical. The series of patients reported is becoming of fair size, and the number of individuals benefited, many tremendously, attests to the therapeutic value of the procedure. This operation can be performed on very seriously ill patients in cardiac failure without an unreasonable mortality.

We have operated on a limited number of patients. The results have been gratifying, and it is hoped that an analysis of these patients will clarify some of the remaining problems and accentuate the important points in technic which must be adhered to for improved results.

There have been 16 patients operated on. In spite of careful study, one was proved to have mitral regurgitation and not stenosis. This patient, then, can be counted only as an exploratory operation.

Operative Technic

Patients who were digitalized prior to operation were continued on digitalis postoperatively. The 3 patients having a sinus rhythm preoperatively who were not in heart failure received no digitalis preparation preoperatively. Preoperative medication consisted in most cases of either 75 or 100 mg. of Demerol and 1/150 grain of atropine or scopolamine. We prefer atropine.

Anesthesia was induced in some cases by sodium pentothal, on others by cyclopropane and continued always by ether-oxygen in a closed system with intratracheal intubation. We are unable to state categorically that any of these variations made any difference in the anesthetic problem, although our impression is that the less preoperative sedation and depression the better.

The incision used has been a parascapular one on the left, beginning at the fifth rib in the anterior axillary line and extending up to the level of the fourth rib posteriorly. The scapula is displaced upward and a major portion of the fifth rib removed subperiosteally, and the pleural cavity entered through the bed of the rib. Five cubic centimeters of 2 per cent Novocain are injected into the pericardial cavity and after five minutes the pericardium is opened, usually posterior to the phrenic nerve,

*From the Thoracic Surgical Service, Marquette University School of Medicine.

from above the pulmonary artery halfway down the ventricle. The base of the auricular appendage is injected with 1 per cent Novocain and a heavy purse-string suture of number three silk is placed about the base of the auricular appendage. A Satinsky clamp is closed over the atrium just below the base of the appendage. The appendage is then opened and if organized thrombi are present, they are dissected out of the appendage. Some of these have required sharp dissection; in others, the thrombi have been only loosely attached.

When the valve will not open at the commissure under reasonable finger pressure, it is cut at the commissure by Bailey's commissurotomy knife or guillotine knife so that the opening is assured to be in the commissure and not across either leaf. This is accomplished by passing the knife or guillotine through openings in a second glove, the first opening being just distal to the distal interphalangeal joint and the second at the level of the proximal finger joint. In most instances, it has not been necessary to tighten the pursestring about the finger to prevent loss of blood but if the opening is too large, the pursestring may be snugged up about the finger by an assistant so that there is no loss of blood during the intra-atrial maneuvers.

The pursestring suture about the base of the auricular appendage is then pulled tight as the finger is removed, the excess appendage cut away, and the appendage closed with interrupted sutures of fine silk. The pericardium is closed loosely with interrupted sutures leaving a fair amount of opening over the center of the ventricle so that any pericardial fluid may escape into the pleural cavity. An airtight intercostal tube drain is placed in the mid axillary line through the eighth or ninth interspace for underwater drainage, should there be any, for the first 48 hours. The chest wall is closed with interrupted sutures in the rib bed after severing the fifth intercostal nerve posteriorly.

In patients who have been in severe cardiac failure for months, the anesthetic problem is a real one. It is impossible in some of these patients to prevent cyanosis during induction and during the first stages of the operation. Blood pressure is likely to be rather low, and the pulse is feeble. As soon as the valve is opened, however, there is dramatic improvement. If cyanosis has been present, it disappears, the pulse becomes much stronger, and the blood pressure is likely to climb to preoperative or higher levels immediately.

Postoperatively these patients are given oxygen by nasal tube or catheter for the first three to four days. In virtually all instances they have taken all fluids by mouth and in the one or two instances that nausea has been present, they have been given intravenous fluids with great caution, maintaining them in a slightly dehydrated state.

The group of patients is too small for any statistically valid conclusions to be drawn but sufficient for evaluation of certain benefits and delineation of broad principles. It is apparent that individuals with a tight stenosis and not a great deal of cardiac enlargement have had better results than patients with lesser degrees of stenosis and greater amounts of cardiac enlargement. Patients who have had a moderate amount of regurgitation at the time of operation and whose regurgitation has not been increased by opening the valve have still had a degree of improvement postoperatively sufficient to warrant the operation.

Four patients have been done too recently to assess the degree of improvement, and one patient can be counted only as an exploratory operation since she had no mitral stenosis and, of course, no benefit was forthcoming.

Case Reports

Two rather typical case reports are briefly summarized to indicate the degree of preoperative disability and the amount of activity which can be attained postoperatively.

Case 1—Mrs. M.F., age 34, had rheumatic fever at the age of 12. Her activities had been limited for the past 10 years. She had two children, ages 11 and 3. She had been on digitalis medication for the past four years. She climbed one flight of stairs with considerable difficulty, having to stop and pant before she went any farther. She did most of her housework but quite slowly. She made a bed a half of a bed at a time and sat down to rest between times. She had normal sinus rhythm. She was unable to walk on the level for more than one block without getting considerable dyspnea. She required at least two pillows for sleep.

Cardiac catheterization revealed a pulmonary artery pressure of 132/60 mm. of mercury.

A mitral commissurotomy by finger fracture was performed on Nov. 2, 1951. Her mitral valve orifice was less than 1 cm. in diameter prior to the commissurotomy. There was grade I regurgitation. After finger fracture there was still grade I regurgitation, but the valve orifice was more than 2 cm. in diameter. She made an uneventful convalescence, and on Dec. 27, 1951 she reported as follows: She was able to walk through deep snow to do her Christmas shopping; she did all her housework without dyspnea; and she had walked as much as 10 blocks without any evidence of shortness of breath. The patient considers herself entirely well although, of course, she cannot possibly have a normal heart.

Case 2—C.W. was a 47 year old white male whose first complaint referable to his heart was pain. This began 13 years ago, recurred frequently at rest and usually at night. He had been rather weak and exhausted after moderate exercise. In 1932 he had scarlet fever and had frequent quinsy prior to that time. In January 1949 he had an episode of acute heart failure and began to fibrillate. He had been on digitalis since that time. Since 1949 his complaints were those of substernal pressure and palpitation and some difficulty in breathing.

In September 1949 he had his first gross hemoptysis. This occurred again in January 1950. In August 1950 it was necessary to start mercurial diuretics. This helped in controlling his exertional dyspnea. In

October 1950 he had another episode of hemoptysis. He had a cardiac catheterization on Feb. 28, 1951. His heart was semi-vertical and showed a small left ventricle. There was a double auricular contour and moderate posterior enlargement of the left atrium. No intracardiac vascular calcifications were seen.

He had a finger fracture commissurotomy on Aug. 10, 1951. His mitral valve was partly calcified and there was grade II regurgitation. After finger fracture he had possibly a little more regurgitation than before, but his valve orifice measured close to 3 cm. in diameter.

Within a month after his operation he was able to walk three miles without difficulty and was able to climb two to three flights of stairs without dyspnea. Prior to surgery three to four steps were all that he could manage. He has continued to fibrillate and is still maintained on digoxin. He has no more dyspnea, orthopnea, or paroxysmal nocturnal dyspnea. He had recatheterization of his heart approximately six months following surgery.

The following figures are given for comparison:

TABLE 1—*Case 2, comparison before and after operation.*

Site	Before	After	Normal
Right auricle	12.5/2 mm.	8/1 mm.	4–8/0
Right ventricle	70/0 mm.	37/0 mm.	20/0
Pulmonary artery	50/30 mm.	30/15 mm.	20/10
Pulmonary capillary Oxygen consumption at rest	234 cc./min.	240 cc./min.	
Oxygen consumption after exercise	342 cc./min.	685 cc. min.	
Cardiac index	1.93	2.72	2–3
Resting cardiac output	3.5 l./min.	5.06 l./min.	4–6
Cardiac output after exercise	5.02 l./min.	8.70 l./min.	6–10

There was some decrease in the size of his heart postoperatively.

Tables 2 and 3 reveal some of the pertinent data preoperatively and postoperatively.

Results have been considered excellent when individuals no longer needed mercurial diuretics, could climb two flights of stairs, and could walk 10 blocks without dyspnea. Results were considered good if patients could climb two flights of stairs and walk 10 blocks with only minor degrees of dyspnea.

TABLE 2—*Results*

Age Group	No. of patients	Excellent	Good	Poor	Expired
30–40	4	4			
40–50	6	3	2		1*
50–60	2		1***	1**	

*This patient died two months postoperatively of a Staphylococcus albus septicemia which could not be controlled by antibiotics. Autopsy showed mural thrombi in the ventricle, none on the valve.

**This patient, age 51, had a good result for about a month and then additional cardiac irregularities developed which restricted his activity.

***This patient, age 60, had an excellent result as far as cardiac status was concerned but had a mild cerebral embolus which has cleared, but cerebral arteriosclerosis still prevents normal activity.

TABLE 3—*Complications*

Cerebral emboli	3
Peripheral emboli	None
Pericarditis	1
Empyema	None
Cardiac failure	None
Septicemia (Expired)	1

One patient had weakness of the face, left arm, and left leg which cleared in six weeks. One had speech center involved and transient right arm weakness. The speech difficulty gradually improved over a two month's period. One patient developed hemiopia which persisted.

(F.R.) 425 East Wisconsin Avenue.

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FELLOWSHIPS FOR BASIC RESEARCH IN ARTHRITIS

The Arthritis and Rheumatism Foundation is offering to qualified individuals research fellowships in the basic sciences related to arthritis. Fellowships will be granted on both the predoctoral and postdoctoral levels, and will run for one year with prospect of renewal.

The predoctoral fellowship will range from $1,500 to $3,000 per annum depending on the family responsibilities of the fellow, and the postdoctoral fellowships will range from $3,000 to $6,000 on the same basis.

The deadline for applications is November 1, 1952. Applications will be reviewed and awards made by February 15, 1953.

For information and application forms, address the Medical Director, The Arthritis and Rheumatism Foundation, 23 West Forty-Fifth Street, New York 36, New York.

The Selection of Candidates for Mitral Valve Surgery*

By HOWARD L. CORRELL, M. D., NATHAN GROSSMAN, M. D., ARMIN R. BAIER, M. D., TIMOTHY R. MURPHY, M. D. and PAUL G. LA BISSONIERE, M. D.

Milwaukee

THE development of safe and effective technics for surgical correction of mitral stenosis demands accurate preoperative diagnosis. Poor surgical results are primarily due to improper case selection. Thus far surgical correction of aortic and tricuspid valve lesions and mitral insufficiency have not been successful. Indeed, surgical correction of mitral stenosis in a patient with lesions of the aortic valve usually makes the patient worse and may lead to progressive heart failure and death. These factors further emphasize the necessity for accurate preoperative diagnosis.

Unfortunately, the commonly accepted clinical criteria are not sufficiently exacting to serve alone in the selection of candidates for surgery. The physician who relies on murmurs will frequently draw incorrect conclusions about the circulatory dynamics. This is particularly true with the apical systolic and basal diastolic murmurs. The intensity of the murmur does not accurately quantitate the altered dynamics of the valve, nor does the location and timing determine the valvular origin of the sound. Thus, a basal diastolic murmur may be due to aortic insufficiency, or a relative pulmonic insufficiency. An apical systolic murmur may be found in a patient who has a mitral stenosis which could be relieved by surgery. Reliance upon murmurs alone would, in these instances, deprive suitable candidates of their best chance for help.

By combining old and new technics, it is possible to increase our accuracy in selection of candidates for mitral valve surgery.

The history and physical examination give enough information to make a preliminary selection of patients. The symptoms that direct our attention to the possibility that the patient has a surgically correctable mitral stenosis are the well recognized ones of progressive weakness, due mainly to reduced cardiac output, and of gradually increasing breathlessness, cough, and hemoptysis, due principally to pulmonary vascular congestion. Later symptoms in the more advanced cases, with failure of the right side of the heart, are upper abdominal distress and dependent edema. Some of the patients will show embolic phenomena, the result of fragmentation of intracardiac thrombi. Manifestations of these embolic phenomena may first call attention to the patient's mitral stenosis.

In all patients whose symptoms are progressive, surgery is indicated if mitral stenosis can be proved the sole or dominant lesion causing cardiac disability.

The following physical findings support a diagnosis of mitral stenosis but do not establish its dynamic significance with the accuracy required for surgery.

1. An apical presystolic crescendo murmur, or, if auricular fibrillation is present, a mid-diastolic rumbling murmur sharply localized at the apex and often heard best in the left lateral recumbent position.
2. Accentuation of the apical first sound and pulmonic second sound, often with splitting of the latter.
3. Occasional demonstration of a "mitral opening snap" inside the apex area, or of a diastolic thrill at the apex.

Left ventricular enlargement is often associated with aortic or mitral insufficiency, or systemic hypertension. Under these circumstances mitral valve surgery is contraindicated. However, displacement of the apex downward and to the left does not always mean left ventricular enlargement, since such displacement can be produced by marked enlargement of the right ventricle. We should be critical of the evidence we accept for left ventricular enlargement and must rely on the x-ray examination. Before concluding that the patient has aortic insufficiency, other evidence must be found, such as left ventricular enlargement and celer pulse.

Auricular fibrillation, while often evidence of advanced cardiac disease, is not a contraindication to surgery. It does, however, suggest the likelihood of an increased incidence of embolic complications following surgery.

Thus, in the clinical evaluation of the patient, the history gives evidence that progressive cardiac disease is present. The physical findings are qualitative. If mitral stenosis is suspected, cardiac fluoroscopy and electrocardiography should be employed.

Electrocardiography is important in determining the heart rhythm, the presence of ventricular hypertrophy, and the presence of myocardial infarction.

X-ray demonstration of right ventricular enlargement and calcification of the mitral leaflets also support the diagnosis of mitral valve disease. The presence of left ventricular enlargement is evidence of dynamic aortic or mitral insufficiency. A markedly enlarged left atrium sometimes is suggestive of a large degree of mitral insufficiency. The significance of systolic pulsation of the left atrium as a measure of mitral insufficiency is not clearly understood at present. Calcification of the mitral leaflets may indi-

* From the Cardiovascular Section of the Department of Internal Medicine of Marquette University School of Medicine and the Variety Club Heart Center.

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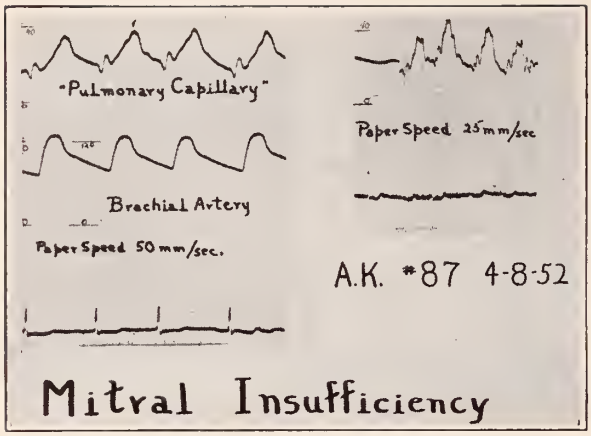

Fig. 1.—The tracings at the top left and right are both "pulmonary capillary" curves recorded at different speeds. Note that curve begins its ascent near the T wave of the electrocardiogram, reaching its peak after the T. Also note the similarity in timing to the Brachial artery pressure.

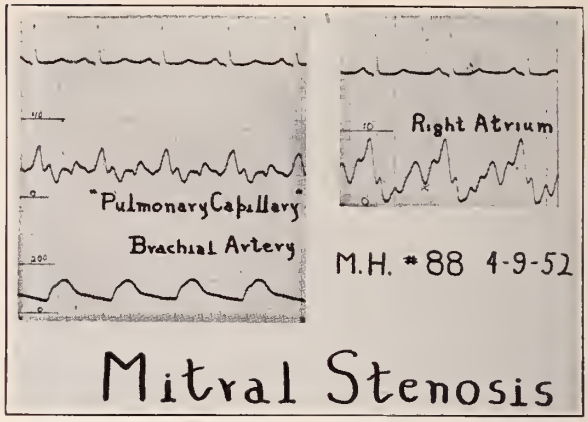

Fig. 2.—Note the similarity between the "pulmonary capillary" tracing and that of the right atrium. The peak of the curve occurs during or shortly after the QRS, and BEFORE the rise of the Brachial Artery Curve.

cate surgical difficulty, increased embolic complications, and poorer operative result.

The information obtained from the diagnostic procedures described above usually is sufficient to separate the patients who are likely to be benefited by mitral valve surgery from those who are not. In many instances, however, the additional data that can be obtained by cardiac catheterization studies are of added importance. It should be performed in all patients where the diagnosis of mitral stenosis is in doubt, and in those suspected of having other conditions which contraindicate mitral valve surgery.

In addition, by means of this technic, it is possible to measure the pressure in the pulmonary circuit, estimate the cardiac output, calculate the size of the mitral orifice, and determine from the type of capillary tracings whether stenosis or insufficiency is the predominant defect. In mitral stenosis with sinus rhythm the retrograde left atrial deflection is increased in amplitude in the pulmonary "capillary tracing." In mitral insufficiency with sinus rhythm a marked deflection in the "capillary tracing" occurs due to the retrograde impulse of left ventricular systole. In auricular fibrillation with mitral stenosis the auricular deflection is absent but the "capillary" curve is of plateau type, whereas in dominant mitral insufficiency, rapid ascent and descent of the limbs of the tracing are present.

With the use of these technics we have studied 20 patients with mitral stenosis coming to surgery, with only a single error in diagnosis. The failure was a patient whose murmur was characteristic of mitral stenosis, but who was found at surgery to have predominant mitral insufficiency. She was in advanced congestive heart failure which made catheterization difficult. The data obtained were incomplete. Surgical exploration was performed because of the progressive downhill course and was without help to the patient. Seventeen days after the operation she expired of heart failure complicated by jaundice which was present prior to surgery.

In no case where satisfactory "capillary" curves were recorded was there an error in the decision as to operability. However, in several instances the degree of insufficiency made estimation of the dominance of stenosis questionable. In these cases exploratory surgery was suggested.

Summary

1. Mitral valve surgery is indicated in patients with inactive rheumatic mitral valve disease, predominantly stenosis, without other dynamically significant valvular deformities, who show evidence of progressive cardiac impairment or have embolic accidents.

2. Selection of operative cases by clinical examination alone may be hazardous.

3. Contraindications to surgery in mitral stenosis are as follows:

(a) Failure of symptoms to be progressive.

(b) Marked or dominant mitral insufficiency.

(c) Appreciable enlargement of the left ventricle due to significant aortic valve disease, mitral regurgitation, or coronary artery disease.

(d) Active rheumatic carditis or bacterial endocarditis.

(H.L.C.) 161 West Wisconsin Avenue.

Clinicopathologic Conference

Editors—W. A. D. ANDERSON, M. A., M. D., Marquette University School of Medicine, Milwaukee
and D. M. ANGEVINE, M. D., University of Wisconsin Medical School, Madison

PRESENTATION OF CASE*

The patient, a 45 year old white male accountant, was admitted to the Evangelical Deaconess Hospital on June 7, 1952 complaining of severe dyspnea and ankle edema. He was transferred from Milwaukee County Emergency Hospital where he had been treated for acute congestive heart failure with marked arrhythmia. The past history revealed scarlet fever at 15 years of age and rheumatic fever at 21. Cardiac symptoms were first noted 7 years before admission, when because of auricular fibrillation he was placed on digitalis. Hemoptysis occurred two years later. Congestive failure developed for the first time two years before admission. He had had recurring episodes of failure since and at least one period of digitalis intoxication which necessitated hospitalization. Dyspnea, orthopnea, and dependent edema became progressively more severe until he was no longer able to walk and finally to leave his bed. The past history, history by systems, and family history were otherwise noncontributory.

At the time of admission he appeared chronically ill, undernourished, and was severely dyspneic and orthopneic. The lungs were clear to percussion, but numerous moist bubbling rales were heard in all lung fields. The blood pressure was 104/80, and the heart rate was rapid (108) and irregular. The heart was enlarged to the left anterior axillary line with a diffuse apex beat. No thrill could be palpated. A rumbling diastolic murmur was audible in the mitral area. A smooth, slightly tender liver edge was palpable 5 cm. below the right costal margin. The lower extremities exhibited grade 2 pitting edema.

The patient had been examined one week prior to admission at the Variety Club Heart Center, Milwaukee, where clinical, electrocardiographic and cardiac catheterization studies were carried out. The pertinent data obtained were as follows: cardiac output 2.3 liters per minute; cardiac index 1.2 liters per minute per square meter of body surface; arterial oxygen saturation 85 2 per cent; main pulmonary artery pressure 100/15 mm. of mercury; right brachial arterial pressure 160/60 mm. of mercury; pulmonary capillary curves revealed a sustained diastolic phase. A conference decided that while there was a strong possibility that aortic valvular disease of moderate dynamic consequence existed it was not important enough to give rise to left ventricular failure and the important lesion was mitral stenosis. Exploration with the idea of performing a mitral commissurotomy was recommended in spite of the extreme illness of the patient. It was felt that without intervention death from mitral stenosis was eminent.

In anticipation of surgery, the patient was placed on bed rest, a low sodium diet, oxygen by nasal catheter as needed, 0.25 mg. of digoxin daily, and 2 cc. of mercuhydrin intramuscularly every other day. Under this regimen the congestive failure subsided, and the patient's general condition improved except for a small hemoptysis on the day before surgery.

Dr. H. F. Twelmeyer: This case represents one of the complications of mitral valve surgery. The patient was in Dexter's class four and was considered a very poor surgical risk. It was felt that the mechanical obstruction at the mitral valve had been adequately relieved at surgery and, barring complications, a good functional result could have been anticipated.

The left chest was entered through the bed of the left fifth rib, and the lung was allowed to deflate. At this time the cardiac rhythm changed from a rapid auricular fibrillation to a ventricular tachycardia of approximately 160 beats per minute (continuous electrocardiographic monitoring by Dr. T. R. Murphy). Five millimeters of 2 per cent procaine were instilled into the pericardium but no change in the rhythm was noted. Therefore, an additional 5 mm. of 2 per cent procaine were instilled into the pericardial sac. Five minutes later the pericardium was opened anterior to the left phrenic nerve. The base of the left auricular appendage was then infiltrated with 1 per cent procaine. The appendage was moderately enlarged, being approximately one and one-half times the size of my thumb. The pulmonary artery was very large, being approximately two and one-half times the diameter of the aorta. No thrill was felt over the left atrium. Manipulation of the base of the appendage while inserting a purse-string suture resulted in some cardiac irregularities and partial conversion of the ventricular tachycardia to runs of auricular fibrillation. This change in rhythm was particularly noticeable when the Satinsky clamp was placed across the base of the appendage. A very small adherent thrombus in the tip of the appendage was excised. The pulmonary vein orifices were explored with the examining finger, and the mitral valve was palpated. The stenotic mitral valve exhibited one-half to one plus degree regurgitation. The valve orifice was slit-like, approximately 2 fingerbreadths in length. The anteromedial cusp and the posteromedial commissure were calcified. These calcified plaques measured

*From the Evangelical Deaconess Hospital, Milwaukee; **Dr. H. F. Twelmeyer**, surgeon; **Dr. C. R. Olson**, internist; and **Dr. Robert S. Haukohl**, pathologist.

approximately 2 by 1 by 0.4 cm. in thickness. The region of the commissures could be felt bilaterally. A finger could be inserted into the ventricle by spreading the narrow lips of the mitral orifice. This did not mean, however, that there was a significant opening always present and that the degree of regurgitation was marked. The forefinger was then withdrawn and reinserted with a Bailey commissurotomy knife. The posteromedial commissure was cut to the mitral valve ring. A smaller incision was made in the anterolateral commissure. At the close of the procedure it was estimated that two to two and one-half fingers would go through the mitral orifice with ease. There was noticeable relief of the stenosis and an increase of the degree of regurgitation to one to one and one-half plus. During the intracardiac manipulation, the cardiac rhythm was a ventricular tachycardia. Only occasionally were more forceful, slower beats noted. At the conclusion of the procedure the purse-string around the base of the auricular appendage was drawn taut, and excess auricular appendage was excised. The chest was closed in the usual fashion with an intercostal tube in the ninth interspace of the posterior axillary line. The operative procedure itself was entirely uneventful—a total of 90 minutes used.

Approximately midway through the operation the blood pressure was extremely low. This persisted through the remainder of the operation. At the close of the procedure a rapid ventricular tachycardia persisted. The patient responded to supra-orbital pressure. In an attempt to convert the ventricular tachycardia, pronestyl was given intravenously slowly at the rate of 100 mg. per minute for a total dosage of 600 mg. (During the middle of the operation, Dr. T. R. Murphy had unsuccessfully used pronestyl in an attempt to convert the ventricular tachycardia.) Approximately midway during the administration of this drug, respiratory depression was noted and artificial respiration had to be maintained by means of the anesthesia machine and oxygen bag. To combat the persistent low blood pressure the patient was given an intra-arterial transfusion of blood and plasma using the left radial and femoral arteries. Methedrine and Coramine were also administered. Respiratory depression continued for two and one-half hours following the close of the operative procedure, and it was necessary to maintain artificial respiration. Eventually the patient began to breathe spontaneously and maintained adequate oxygenation. During the period of respiratory arrest he had fibrillary twitchings in the left upper anterior chest muscles. He moved his left arm and the left side of his face in response to painful stimulation, but no movements were noted in the right arm and leg. His rectal temperature just prior to return to his room was 100 F.

The patient's unconscious state was prolonged until about 10 hours after surgery when he appeared to respond to simple commands. He was aphasic and had marked paresis of the right half of his body. He moved his right arm and right leg *en masse*. Left stellate ganglion blocks were performed immediately following surgery and at intervals throughout the postoperative course. These had no apparent effect on his condition. His temperature continued to rise, and he became comatose approximately 36 hours following surgery. He remained comatose with a very high temperature until the time of his death, a day and one-half later.

Dr. C. R. Olson: As is well known, valvular heart disease is common. Paul White has estimated that 0.5 to 1.0 per cent of the community at large is affected, particularly in those areas where rheumatic fever is endemic as in northeastern United States and in northern Europe. The great majority of persons afflicted with rheumatic heart disease (up to 85 per cent) develop some degree of deforming valvular disease, the mitral valve being the most common site of involvement. Structural stenosis of the mitral valve is the most deforming end result of rheumatic infection.

The prognosis of an individual case of mitral stenosis depends upon many factors: (1) age of the patient; (2) severity of the lesion; (3) presence or absence of other valve defects; (4) presence or absence of additional rheumatic activity; and (5) the condition of the myocardium.

The ultimate outcome is almost invariably unfavorable once the stenotic change gives rise to a progressive pattern. Thus, when the diagnosis of early mitral stenosis has been established by the cardiologist, he can predict with considerable accuracy, both by repeat physical examination and observation of the patient's general condition, the structural and symptomatic phases through which a given case will pass. His treatment will at once be directed toward the prevention of further rheumatic insults and the support of the myocardium which is attempting to maintain adequate systemic circulation in the face of an increasing mechanical stricture. Under such circumstances both cardiologist and myocardium are fighting a losing battle.

One of the most feared complications of rheumatic mitral disease is the formation of intracardiac thrombi with the threat of multiple embolization. The commonest cause of mural thrombi is myocardial infarction. Rheumatic heart disease ranks second with thrombosis on the wall of the left auricle or its appendage, especially in the presence of auricular fibrillation which so commonly complicates mitral stenosis.

In view of the possible promise of recent surgical developments, one is forced to the conclusion that heart disease as a whole and mitral stenosis in particular must be viewed by the cardiologist from an entirely new perspective. Thus, the first signs of development of mitral stenosis demand immediate and repeated evaluation by all possible methods to include (in addition to the physical examination): (1) electrocardiograms; (2) teleoroentgenograms, esophagrams, and cardiac fluoroscopy for estimation of the size of the individual cardiac chambers, (3) ex-

ercise tolerance tests; and (4) laboratory examination for the detection of present rheumatic activity.

Such a program, has, in the past, been the standard means of determining the benefit derived from therapeutic measures. To this we must add procedures for the detection of early physiologic changes.

To evaluate cases for surgical intervention there must be included: (1) estimations of cardiac output at rest and with exercise as calculated with ballistocardiography; and (2) determinations of the pulmonary arterial and right ventricular pressures by cardiac catheterization.

There are three basic questions to be answered when considering a subject for medical evaluation:

1. Has the primary rheumatic infection completely subsized? What is the probability of recurrence? What effect would recurrence exert upon the valve that has been subjected to operation?—No clear-cut answers can be provided, but present activity can be detected and future exacerbations can be prevented in large measure by the established practice of intermittent and long continued antibiotic or chemotherapeutic agents.

2. Is the valvular deformity such that the patient cannot reasonably expect a normal life span with but moderate limitation of activity?—Preliminary evaluation by measuring the pressures within the pulmonary circuit may well be paramount in the making of such a decision. There is strong suspicion that systolic pressures of 50 mm. of mercury within the pulmonary artery may represent the critical level above which the patient must shortly expect serious consequences.

3. To what extent may stenosis be permitted to develop before all reasonable chance of surgical relief is lost?—Results obtained to date strongly suggest that in far advanced cases where patients with fixed, calcified valves who have or have repeatedly had heart failure, the opportunity has been lost.

The maintenance of a low surgical mortality and the degree of improvement desired require that the patient be a fair surgical risk, that his lesion be primarily early and primarily stenotic, and that his myocardium, although strained by overwork, be capable of restoring a normal cardiac output once obstruction of the pulmonary outflow has been relieved.

The indications and contraindications for commissurotomy must be considered together. Both must change as experience dictates. Common sense and present experience have led to certain conclusions:

I. *Most Favorable Group*—Those having:
   A. Excessive fatigability with increasing exertional dyspnea.
   B. No rheumatic activity at present.
   C. Normal sinus rhythm (Auricular fibrillation is not an absolute contraindication.)
   D. A lesion which is predominantly stenosis.
   E. Evidence of significant increased pulmonary hypertension.

II. *Less Favorable Group*—Includes the above plus:
   A. Recurrent bouts of hemoptysis.
   B. Arterial embolic phenomenon.
   C. Auricular fibrillation without heart failure.

Contraindications

   A. Active rheumatic infection.
   B. Super-imposed subacute bacterial endocarditis.
   C. Cardiac failure not controlled by using methods.
   D. Presence of marked associated mitral regurgitation or other valve deformities (aortic).

Necropsy Findings

Dr. Robert S. Haukohl: An autopsy was performed one and one-half hours after death. External abnormalities consisted only of the operative wounds and numerous vein and arterial puncture wounds. Edema and cyanosis were not apparent. All body cavities contained a normal amount of fluid except for a slightly increased amount of blood-tinged fluid and a few blood clots in the left pleural cavity and the pericardial sac. The right lung was rather voluminous and adherent to the parietal pleura at the apex. The left lung was collapsed against the mediastinum partially covering an incompletely closed pericardial operative wound anterior to the left phrenic nerve.

The heart was massively dilated, particularly the left atrium and the entire right side. It measured 16 cm. across the base and 14 cm. from base to apex. It weighed 750 Gm. A small amount of blood-tinged fibrinous material coated the epicardial surface, particularly in the region of the operative site in the left auricular appendage. A purse-string of black suture material was found at the base of the auricle incorporated in a mass of thrombotic material. The tip of the auricle was absent. Upon opening the right heart, enormous dilatation was apparent, the tricuspid valve orifice measuring 16 cm. in circumference. The right ventricular wall was moderately hypertrophied, averaging 0.7 cm. in thickness near the base. The pulmonary orifice measured 9 cm. in circumference and showed no intrinsic lesion. The left atrium was moderately dilated but only a small amount of thrombotic material could be found within the stump of the auricle. The mitral orifice exhibited an advanced degree of fish-mouth stenosis. The posteromedial commissure and the medial half of both the anterior and posterior cusps were completely calcified and somewhat nodular leaving but a narrow slit-like rigid orifice. Both leaflets were stiff and fibrous in their lateral halves but could be flexed upon the valve ring because of two valvulotomy incisions. The longer of these [Fig. 1 (A)], approximately 1 cm. in depth was situated in the center of the posterior cusp just lateral to its calcified portion. The shorter [Fig. 1(B)], approximately 0.6 cm. in depth, was present on the anterior cusp just medial to the anterolateral

Fig. 1.—A horizontal section through the heart just above the mitral valve. The dilated left atrium has been trimmed away. The mitral valve displays marked distortion; the posteromedial commissure is completely calcified. Valvulotomy incisions are apparent at "A" in the posterior cusp and at "B" in the anterolateral commissure.

commissure. The posterior incision was rather ragged, and small pieces of calcific material could be dislodged from its medial edge and the adjacent nodular mass within the leaflet.

The left ventricular wall displayed moderate hypertrophy, averaging 1.6 cm. in thickness near the base. The muscle was firm and reddish-brown but showed focal fibrotic scars ranging up to 0.5 cm. in diameter. The aortic valve orifice was of normal circumference, but the leaflets displayed moderated nodular fibrous thickening at their bases and contact edges. The free margins were stiff and rolled inward. The coronary arterial tree was unaltered.

Other remarkable gross anatomic findings in the body cavities consisted of slight chronic passive congestion of the lungs as well as the left atelectasis alluded to, moderate congestive hepatomegaly and splenomegaly, and congestion of the kidneys.

The brain weighed 1,340 Gm. It was symmetrical and showed normal thin-walled blood vessels at the base. Section, however, revealed a large area of encephalomalacia, roughly pyramidal in shape, extending posteriorly from the left frontal lobe tip to a point opposite the junction of the parietal and occipital lobes with the apex involving the left basal ganglia and hypothalamus. A similar but smaller area of softening was found in the right parietal lobe 2 cm. beneath the cortex.

The significant histopathologic changes were confined to the heart, lungs, and brain. The aortic valve leaflets displayed changes characteristic of chronic rheumatic valvulitis with marked scarring. All sections of myocardium, but particularly those taken from the left ventricular wall, showed large, often confluent areas of interstitial perivascular fibrosis. There was extensive replacement of muscle and marked associated hypertrophy. None of these areas showed evidence of rheumatic activity, although a few small round cells and occasional Anitschkow myocytes were found. The lungs exhibited focal bronchopneumonic consolidation, moderate edema, and evidence of long standing chronic passive congestion.

The cerebral sections showed changes characteristic of encephalomalacia of several days duration. No embolic material could be identified in the smaller vessels of either hemisphere.

In spite of the absence of objective evidence, I believe that cerebral embolization occurred in this case because of the extent and location of the areas of infarction. The emboli were undoubtedly liberated into the blood stream during surgery. They were either small pieces of thrombotic material from the left auricle or calcific fragments from the posterior mitral cusp. The first would appear more likely since valvular debris should be readily demonstrable within the cerebral vessels.

In addition to severe chronic rheumatic mitral stenosis this patient had chronic aortic valvulitis of moderate severity and marked myocardial fibrosis presumable on a basis of antecedent rheumatic myocarditis. Both undoubtedly contributed to the left ventricular myocardial hypertrophy in some degree.

Doctor Twelmeyer: Cerebral emboli following mitral commissurotomy occur in approximately 5 to 10 per cent of cases. In many cases we have tried to obviate this complication by having the anesthetist apply pressure to the common carotid arteries as intracardiac manipulation was being carried out. Unfortunately, in this particular case this maneuver was not done. It is felt that an even better maneuver would be that described by Bailey and his co-workers in which a non-crushing clamp is placed across the base of the innominate artery at the arch of the aorta and an umbilical tape is placed about the left common carotid artery near the arch of the aorta. This would not give the long column of static blood in the carotid that one would get by external pressure on the carotid by the anesthesiologist. Thus, a small embolism is much more likely to be swept past the mouths of these vessels and deposited in the small vessels peripherally. It is our feeling that manipulation and palpation of the calcified valve in many instances break off small emboli. These calcified valves are very irregular and when force is used to dilate the valve or tear the commissures, it is very easy to understand how a small fargment of calcium or thrombus on the valve may be dislodged. Indeed, the irregularities in the valve are sometimes so marked that the surgeon's glove may be torn. Thrombus within the auricular appendage may be a source of emboli. It has been our experience, however, that the majority of these thrombi are strongly adherent and can be controlled readily by the non-crushing clamp applied across the base of the auricular appendage. After one dissects the adherent thrombus free from the appendage wall, one momentarily opens the clamp and allows a gush of blood to wash out of the heart whatever thrombotic material is present or may have been caught in the clamp.

THE MEDICAL FORUM

GRIFFTH INSTALLED AS SOCIETY PRESIDENT; TENNEY NAMED PRESIDENT-ELECT FOR 1953

J. C. GRIFFITH

H. K. TENNEY

Milwaukee, Oct. 8.—Dr. J. C. Griffith, Milwaukee, was installed as president of the State Medical Society at the annual dinner of the society Tuesday night October 7. He received the gavel from Dr. A. H. Heidner, West Bend, president during 1951–52.

Dr. Griffith is a past president of the Medical Society of Milwaukee County and is currently a member of the board of directors of that society. He has served as a delegate to the state society in previous years.

Dr. H. K. Tenney, Jr., Madison, was named president-elect of the State Medical Society at the final session of the House of Delegates.

Dr. Tenney will take office in October 1953. He is associate professor of pediatrics at the University of Wisconsin. At the time of his election he was speaker of the House of Delegates.

Other officers elected by the House of Delegates were:

Dr. G. E. Forkin, Menasha, speaker of the house; Dr. J. W. Fons, Milwaukee, vice-speaker;

Drs. S. E. Gavin, Fond du Lac and D. H. Witte Milwaukee, re-elected as delegates to the American Medical Association;

Drs. L. O. Simenstad, Osceola, and J. C. Griffith, Milwaukee, re-elected alternate delegates to the American Medical Association.

Five councilors were elected as follows:

Dr. N. A. Hill, Madison, 3rd district, to succeed Dr. H. K. Tenney, Madison;

Dr. E. M. Dessloch, Prairie du Chien, 4th District, to succeed himself;

Dr. A. H. Heidner, West Bend, 5th District, to succeed himself;

Dr. A. J. McCarey, Green Bay, 6th District, to succeed himself;

Dr. W. T. Casper, Milwaukee, 12th District, to succeed Dr. D. F. Pierce, Hales Corners.

"EXPAND HEALTH INSURANCE COVERAGE IN RURAL AREAS," GRIFFITH ASKS

Milwaukee, Oct. 8.—Benefits and coverage in the society-sponsored voluntary health insurance programs need to be expanded as rapidly as possible, declared Dr. J. C. Griffith, new society president, in his address to the House of Delegates.

"Don't Be Too Sure"

He urged the society to give closer attention to the relationship between government and medicine.

"We seem to have won, at least for the present, but let's not be too sure" about the victory over proponents of compulsory health insurance, Dr. Griffith stated.

Extend Benefits

"I go along with the voluntary insurance principle. In Wisconsin almost two million people are covered. This sounds very good, but it isn't enough. Many of those who are insured do not need it, and certainly many of those who need it, are not insured."

"Benefits need to be broadened as rapidly as possible. Service needs to be extended, and catastrophic insurance has to be considered," Dr. Griffith contended.

He urged the extension of the Society's program to rural areas through promotion and vigorous sales.

Commenting on the fact that 40 different federal agencies render some kind of medical service either directly to the patient or through some state agency, Dr. Griffith asked for the establishment of a Council on State Departments in the state society to keep abreast of such programs.

Combine Committees

He said more than $23,000,000 yearly is being spent in various departments of the state government in Wisconsin in the health field alone.

The House later approved his recommendation by combining the committees on Goiter, Care of Crippled Children, Maternal and Child Welfare, Tuberculosis and Chest Diseases, Mental Hygiene and Institutional Care, Visual Defects, Hearing Defects, School Health and Venereal Diseases into one Council.

President Urges Support for Society's Public Relations Program for 1953

Milwaukee, Oct. 8.—Both the incoming president, Dr. J. C. Griffith, Milwaukee, and the House of Delegates gave whole-hearted support to the current public relations program of the State Medical society and urged its continuation in 1953.

The Council on Medical Service, under the chairmanship of Dr. D. E. Dorchester, Sturgeon Bay, was commended for its comprehensive report and constructive public relations efforts throughout the past year.

The House praised Dr. A. H. Heidner, West Bend, past president, for his inter-professional relations program with the press, pharmacists, and attorneys.

The Council on Medical Service was urged to develop an annual state conference in the field of medical-press relations and to encourage the holding of local conferences of the same nature.

At the same time, the council was authorized to develop a guide book on medical-press relations with the thought that it be distributed to hospitals, physicians. newsmen, and to schools of medicine and journalism.

The House also asked physicians to support the industrial health program by participating in the clinics to be held in their areas; to set up county committees to handle medical problems of migrant workers before they become acute; to take special care with reports under the Open Panel program in Workmens' Compensation, and to participate in the Rural Health Conferences being held in Green Bay, Nov. 13; Madison, Nov. 14; Eau Claire, Nov. 18 and Wausau, Nov. 19.

Report on Pesticides Available Upon Request

Chicago, Oct. 1.—The fourth in a series of reports on pesticides has been made available in reprint form by the AMA.

A reprint of the latest report, "Pharmacologic Properties of Toxaphene, A Chlorinated Hydrocarbon Insecticide" may be obtained by writing the office of the State Medical Society, 704 E. Gorham St., Madison.

HOUSE SET DUES AT $60 FOR 1953

Milwaukee, Oct. 8.—State Medical Society dues were established at $60 for 1953, by action of the House of Delegates on Monday, Oct. 6.

In approving continuation of dues at $60, the House explained that dues could not be reduced because of substantial expansion in the society's activities and services to the membership and the impact of inflation. At the same time the House pointed out that dues should not be increased.

Plan to Streamline State Lab Program

Madison, Sept. 19—The central laboratory of hygiene operated by the state board of health in Madison will streamline its far-flung activities next July 1 by taking over some of the testing now being done by eight cooperative laboratories and a branch laboratory.

Dr. Carl N. Neupert, state health officer, said the work to be shifted to Madison includes bacteriological testing in the control of communicable diseases and testing of individual well water samples. The city-operated cooperative laboratories will then be free to concentrate on local milk and restaurant sanitation programs.

He said the state now pays half of the salaries of the cooperative laboratory directors in Beloit, Kenosha, Sheboygan, Oshkosh, Green Bay, Wausau, La Crosse, and Superior. After July 1 the cities will be independent in the operation of their laboratories.

In addition the Rhinelander branch of the central laboratory, employing a bacteriologist and an assistant, will be closed.

The streamlining will follow the opening early in 1953 of a new central laboratory building on the University of Wisconsin campus, Doctor Neupert said. The new building will enable the laboratory to process the specimens mailed in by hospitals, physicians, and health officers more efficiently and to meet the increasing demand for tests of individual wells.

Urge Doctors to Attend Legion Post Meetings

Chicago, Sept. 20—The A.M.A. Board of Trustees has reiterated active interest in the affairs of the American Legion.

Physicians who are members of the Legion were urged specifically to attend meetings of their posts since the policies of the Legion, like those of the A.M.A., are decided at the grass roots level.

Legion delegates adopted a resolution at a recent convention opposing I.L.O. procedures that would socialize medicine by international treaty, and they turned down another resolution which would have mandated the Legion to urge the Veterans Administration to give special recognition to chiropractors.

This would have permitted veterans to choose chiropractic treatment at government expense. A similar resolution for optometry was also defeated. The chiropractor resolution, coming from eight state departments of the Legion, resulted in one of the bitterest battles on the floor of the convention. The fact that it was defeated was remarkable since such large delegations as Illinois, New York, Pennsylvania and Texas voted solidly for the chiropractor resolution.

Several Legion officers explained that such strength is generated at the local level. That is why more doctors should attend meetings of their local posts where health proposals originate.

O.K. Outpatient Care for Spanish–American Vet

Madison, Sept. 24.—Outpatient treatment for Spanish–American War veterans by the home-town doctor is now payable by the Veterans Administration provided the family physician requests authorization not later than 15 days after the treatment was initially rendered.

Requests for authorization may be submitted to the Wisconsin Veterans Medical Service Agency of the State Medical Society in Madison.

The Veterans Administration does not have authority to make payments for hospitalization of Spanish–American War veterans in a private hospital.

DR. STEWART ON COMMITTEE DIRECTING AAPS ESSAY CONTEST ON HEALTH CARE

Chicago, Sept. 18—A $1,000 first prize is being offered in the 1953 Essay Contest for high school students sponsored by the Association of American Physicians and Surgeons in cooperation with State and County Medical Societies.

The subject is "Why the Private Practice of Medicine Furnishes This Country With the Finest Medical Care."

Doctor W. C. Stewart, Kenosha is a member of the 34 man AAPS contest committee supervising the program.

State and County Medical Societies are urged to conduct local contests to stimulate interest in the program.

March 1 Deadline

High school students (tenth, eleventh and twelfth grades) from all public and parochial schools located the United States are eligible to enter the contest—except sons and daughters of physicians. County or State Medical Societies may at their own option include students from seventh, eighth and ninth grades.

Essays must be limited to 1,500 words, typed on one side of letter size paper and double spaced. The contest starts January 1, 1953 and essays must be submitted on or before March 1, 1953 to the County or State Society sponsoring the contest or to the Association of American Physicians and Surgeons, 360 North Michigan Avenue, Chicago 1, Illinois in event no contest is sponsored either by a County or State Society.

Reference Packets

Compositions must be original and well documented and judging will be based solely on knowledge and grasp of a subject supported with documentation, and sound logical conclusions.

Judges for the national contest include a physician, an educator, and another person, all of whom have some special knowledge of the subject.

Small package libraries with bibliography and reference material may be procured free of charge by writing AAPS in Chicago.

W. C. STEWART

"Fringe Benefits" Cost 25 Billion Each Year

Washington, Sept. 23—American employers are paying close to a billion and a half dollars for employe health and life insurance benefits.

This is one of the findings of the U. S. Chamber of Commerce survey of "fringe benefits," for labor costs not shown on the actual payroll.

A total of 736 companies took part in the survey. It groups together "life insurance premiums, death benefits, sickness, accident and medical-care insurance premiums, hospitalization insurance, etc.," and establishes that they cost management an amount equal to 1.4% of its total payroll.

An indication of the rapid increases in employer-financed life-health insurance in the last four years is the fact that the average employer now pays exactly as much for these particular items as for Old Age and Survivors Insurance under U. S. Social Security.

In addition to death and health insurance, fringe benefits include such things as pensions, workmen's compensation costs, terminal pay, profit-sharing plans and payment for time not worked (holidays, lunch hours, etc.) There total costs to management, the Chamber fund, equal 18.7% of payroll.

In dollars the Chamber estimates that American industry annually pays something less than 25 billion for these benefits.

Doctors and Press Set Up "Code of Cooperation"

Columbus, Ohio, Sept. 17—More and more Medical Societies are adopting codes of cooperation with press, radio and TV.

The latest code has been issued by the Columbus Academy of Medicine. The code patterned after the Colorado Code has been printed in a gray brochure with maroon type. Physicians met with representatives of the hospital, press and radio to develop it.

The doctors, in addition, prepared a press directory listing names, addresses and phone numbers of the academy's medical spokesmen and the names and phone numbers of the hospital spokesmen.

CLAIM BLANKS

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Urge Doctors to Contribute to Support of Medical Schools

Milwaukee, Oct. 8.—All Wisconsin physicians are urged to make substantial annual contributions to the American Medical Education Foundation, an organization sponsored by the American Medical Association to provide support for the nation's hard-pressed medical schools.

The House-passed resolution is reprinted here in full:

WHEREAS, many American medical schools are operating with deficits as a result of reduced incomes from endowments, rising costs and depletion of reserves, and many are faced with the prospect of curtailing their facilities unless substantial added financial support is forthcoming, and

WHEREAS, this situation must be met either by donations from the medical profession and other citizens or grants by the federal government, and

WHEREAS, the American Medical Education Foundation was established by the American Medical Association to secure adequate, unrestricted funds for medical education from voluntary sources, and this fund has already turned over more than $1,400,000 in contributions to the nation's medical schools and is now seeking annual contributions of $2,000,000 for the same purpose, and

WHEREAS, the American Medical Association, which annually contributes $500,000 to the fund, urges individual physicians to supplement this amount with contributions of $100 annually, and the success of the program to obtain contributions from physicians will spur significant contributions from industry, business, agriculture and labor, now therefore be it

RESOLVED, that every member of the State Medical Society of Wisconsin demonstrate his support of continued high quality medical education by contributing annually and generously—each according to his means—to the American Medical Education Foundation.

AND BE IT FURTHER RESOLVED, that there be published periodically in the Wisconsin Medical Journal the list of Wisconsin physicians contributing to such fund, and

BE IT FINALLY RESOLVED, that this resolution be sent each member of the Society and periodically published in the Wisconsin Medical Journal with the reminder that physicians may, if they wish, "ear mark" their individual contributions for a medical school of their choice.

FOUR NAMED TO HOSPITAL COUNCIL

The state board of health today announced the appointment of four members to its Advisory Hospital council, a group of citizen consultants in the state-wide program under which federal aid funds are alloted for the building of nonprofit hospitals.

They are William Coffey, consultant to the director of Milwaukee County institutions; Leigh Hunt, secretary-treasurer of the State Association of Wisconsin Architects, and Herbert Vonier, of the Wisconsin State Federation of Labor, all of Milwaukee, and Mrs. John Ramsay, of Peshtigo, Wis., president of the Wisconsin Home Demonstration council.

AMA Wonders If Oscar and Adlai Agree

Chicago, Aug. 12.—It may be a matter of semantics, but Federal Security Administrator Ewing and Governor Stevenson, the Democratic presidential candidate, ought to get together on just what they mean relative to socialized medicine, according to the American Medical Association secretary's letter of August 12.

On July 31, the New York Times devoted a page to questions and answers outlining Governor Stevenson's views on a variety of pertinent national subjects.

One question was: "Would you see eye to eye with Oscar Ewing on the subject of national health?"

Governor Stevenson's answer was: "No, on a number of occasions in the past I have indicated that I thought a new approach was necessary."

Then, on August 1, the New York Times carried a story from Washington, saying "there was no schism" between Oscar Ewing and Mr. Stevenson "on the subject of national health insurance."

"The Democratic platform statement on the cost of medical care," Mr. Ewing was quoted as saying, "is in line with my philosophy and I'm sure with his [Governor Stevenson's]."

"Better Rural Health" to Be Major Theme of Country Life Association During 1953

Madison, Sept. 19.—"Better rural health" is to be the main 1953 goal of the American Country Life Association. This was the decision made at the association's annual meeting held this year in Madison.

The national association represents top-level thinking from organizations interested in rural education, religion and social programs. Its members and officials lay emphasis on the "family operated farm" as against what they call "corporation type" agriculture.

When the session closed on Sept. 18, the directors went on record as seeking more and better physicians and medical facilities in the country. They propose to go after them by sponsoring recruitment programs in the schools, and medical and dental checks of young people who will carry the necessity and importance of such check-ups to the older people.

Milo K. Swanton, Madison, executive secretary of the Wisconsin Council of Agriculture Cooperative and former association president, said:

"Nationally we are deplorably weak as to rural health officers and public health nurses. Farm people accepted the extension service for county agricultural agents and in time they will accept the work of public health nurses."

Aubrey Gates, Chicago, field secretary for the AMA Council on Rural Health, was named to the board of directors of the association.

As part of its 1953 program the association wants to review medical needs of rural America and do something to correct deficiencies where they exist.

Society to Begin Campaign for Student Loan Fund

Milwaukee, Oct. 8.—The State Medical Society was instructed by the House of Delegates to undertake a personal contact and mail solicitation campaign of all Wisconsin physicians as a means of raising $250,000 for the Society's Student Loan Fund.

The physician campaign is to be followed by a public solicitation, the House said.

The Council submitted a detailed resolution on the matter to the House. Prior to voting on the resolution, Dr. H. H. Christofferson, Colby, past president of the society, made a fervent appeal to the delegates to get the Student Loan Fund on a sound financial basis.

Dr. Christofferson said the need for loans to medical students was pressing, that several students have applied for loans, but to date none have been made because there have been insufficient funds.

He indicated that some Wisconsin bankers had proposed supporting the program if physicians would prove their sincerity by contributing a substantial portion of the $250,000.

The full text of the resolution as passed by the House is printed below:

WHEREAS, the modern medical student is faced with an average expenditure in excess of $1,500 annually in connection with his medical training; his curriculum is so exacting that most available time should be spent in study; the length of his course of study often results in his assuming family responsibilities before attaining his medical degree—all of these facts contributing to a situation in which a number of the 600 students in the two Wisconsin medical schools need partial or full financial support if they are to complete their education, and

WHEREAS, the Student Loan Fund of the State Medical Society was established in August 1951 as an instrument to assist needy and deserving medical students, interns and residents, with preference being given to those attending the University of Wisconsin Medical School and Marquette University School of Medicine, and

WHEREAS, a fund of $250,000 is needed by way of contributions from physicians and the public if the program is to be effective and financially sound, now therefore be it

RESOLVED that the State Medical Society of Wisconsin conduct, during the next year, an intensive, county-by county, mail and personal contact solicitation program among the physicians of Wisconsin, and later a separate public solicitation, as a means of accumulating sufficient capital to permit the fund to operate effectively.

Emergency? Call the "MD–OD"

Madison, Oct. 10.—An unusually successfully "emergency call service" has been established by the Montgomery County (Ohio) Medical Society with headquarters in Dayton.

The society has established an "MD—OD" or Medical Director of the Day program whereby every physician in the county periodically serves a 24-hour period on emergency call duty.

The title "MD–OD" has been accepted enthusiastically, according to Byron Ostby, State Medical Society Field Secretary, who heard of the new program at a recent AMA public relations meeting.

Specialists as well as general practitioners serve on the duty tour. Most of the calls are emergencies, and first aid is the most common application of professional talent.

Every effort is made exhaust other medical facilities before the "MD-OD is asked to take a call.

Six Hospitals Seek Federal Funds for Building Programs

Madison, Sept. 15.—Applications for federal aid to build new hospitals or add to existing facilities in six Wisconsin communities were approved Friday by the state board of health.

They are Antigo, Sturgeon Bay, Neillsville, Reedsburg, Spooner, and Hayward.

When completed the projects will provide 188 more hospital beds at a total estimated cost of $3,161,510. After the applications are approved by the public health service in Chicago the government will supply 45 per cent of the funds from an appropriation earmarked by Congress.

Others Plan to Build

The Langlade County Memorial hospital in Antigo plans to build a 39-bed addition costing $1,241,660. The Door County Memorial hospital, Sturgeon Bay, hopes to erect a new 40-bed building for $632,350.

Other fund applications were for a new Neillsville hospital with 34 beds, costing $560,000; a 20-bed addition to the Reedsburg Memorial hospital, $350,000; a new 20-bed Spooner Community hospital, $275,000, and a $102,500 remodeling job on an Indian hospital to create the Hayward Memorial hospital.

Following federal approval the hospitals will submit plans for financing their share (55 per cent) of the construction costs. Then sites and specifications will need approval before the actual contracts are signed and building starts.

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HOW TO CHOOSE AN "AGENCY" FOR COLLECTIONS

This is the second of two articles condensed from an address by Stanley R. Mauck, executive Secretary of the Columbus Academy of Medicine, Ohio. The first article urged physicians to do a better job in their own offices with collection of accounts. This article examines the part that "collection agencies" play in the public relations picture of account handling.

In the first place, it should be acknowledged that there is a definite place in professional practice for use of a reliable and properly operated collection service. People who are normally self-supporting and pay for other services and commodities should also pay the reasonable cost of medical care.

The willful deadbeat and the irresponsible patient should not receive "free" medical care through non-payment of their accounts. To permit them to do so is gross discrimination against the good-paying patient. The judicious use of a responsible collection service is advisable not only to protect the doctor's financial interest, but also in fairness to the conscientious debtor who pays satisfactorily.

Granting this premise, how, then, should an agency be selected so that the vital public relations factor can be protected in this delicate service?

The Professionally-Controlled Agency

There is much to be said for the professionally-controlled collection service. The number of such bureaus is increasing, prompted largely by the profession's growing consciousness of the public relations factor in bill collecting. The pattern of the multiple service bureau, which was long ago established in Columbus, has also demonstrated its usefulness, public relations-wise, in the operations of services other than collections.

The emergency call service is extremely important. Centralized bookkeeping and professional management both help to eliminate some of the unbusinesslike methods which alienate patient good will.

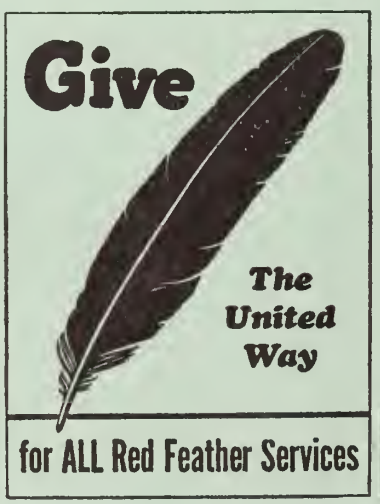
The Columbus professional budget plan contributes to good public relations. Its slogan is, "We would rather prevent bad accounts than collect them." One of the very great assets of the professionally owned or controlled business bureau is its ability to do a professional relations job in every service rendered.

Last year, Mr. L. W. Rember, of the A.M.A. Public Relations Department, made a survey among county medical societies to check their attitude toward collection services. One question was: "Do you think a society-operated collection service can do a better job public relations-wise than a private bureau? Sixty percent of the replies said "yes," thirty percent said "no." Ten percent had no opinion.

My observation, however, is that not all professionally-controlled bureaus are as public relations-conscious as they should be. Some appear to justify their existence by cut-rate collection costs, which is wrong, for this factor should never be the primary consideration in operating a bureau.

And the methods used by others are only slightly less objectionable than those used by many private collection agencies. We should recognize the fact that society or professional control of a collection service does not automatically make it "lily-white."

Most such bureaus, however, deserve the full support of the profession because they know and understand the vital importance of public relations in collecting doctor's accounts.



The Private Agency

Since it is not practical to organize professionally-controlled bureaus everywhere, certain societies are making another approach to the collection agency problem. Mr. Rember's survey revealed that the private bureau, of a certain type, was favored by thirty percent of the societies responding to his questionnaire.

Some are unquestionably operating in a thoroughly satisfactory manner and doing a good PR job.

This type of bureau is usually approved by the society or granted official recognition in return for concessions in operating policy that meet the special needs of the profession.

A special committee of doctors may serve as liaison between the society and the bureau to consult with and advise the owner regarding policy and operating procedure.

By group action, members of a county society may thus direct and control the collection methods of a reputable private agency which is willing to cooperate with the society, to the mutual advantage and benefit of both parties. Such an arrangement is worthy of consideration where local circumstances are favorable.

National Association Useful

I have been connected with business bureau operations for 19 years and have studied this service in many cities. We have a National Association of Medical-Dental Bureaus, composed of both professionally-controlled and privately-owned bureaus which make a specialty of rendering business services to doctors.

The purpose of the Association is to develop higher standards in medical business bureau work, to promote a better understanding of how the special needs of the professional office may be met, and to exchange ideas for greater operating efficiency. The Association has performed a very useful function in developing bureaus that deserve the confidence and support of the profession.

Out of my many contacts with bureaus of both types, I agree that it IS possible for a privately-owned bureau to serve the profes-

sion satisfactorily in the field of collections.

To do so, however, the agency must be different from the many commercial agencies which are totally void of any appreciation of the delicate PR factor in collecting for doctors.

The management of the agency must know and understand the problems of the professional practice and be governed by collection policies which conform to good public relations standards. The form or type of organization best suited to handle professional accounts may be debatable, depending on local conditions.

--But what is not debatable is that the factor of public relations is vitally tied in with third party collection procedure and should be of prime consideration in determining the choice of an agency, whether it is professionally or privately controlled.

While the A.M.A. is stressing good public relations in bill collecting, many "grass roots" doctors do not yet realize that a lot of public relations dynamite is tied up in the way their bad accounts are handled when they leave their offices.

It is difficult to expect the independent commercial agency to be more public relations-conscious than are the doctors themselves.

Precautions in Selecting Agency

Where neither professionally-controlled bureaus nor approved private agencies are available, what then, are the doctors to do about their bad accounts? Obviously, it is up to the individual doctor to select an independent collection service which he believes will most nearly handle the accounts in the right manner.

Here are a few precautions which might be well to remember when making such a choice:

(1) select a local agency which has a reputation for reliability and good standing in the community;

(2) out-of-state and mail-order type agencies should be avoided;

(3) investigate the methods used, and ask to see the type of first notice and other follow-up material;

(4) check up on the ownership and financial responsibility of the agency and its promptness in settling for money collected;

(5) as a general rule, don't sign a contract—better agencies seldom use them;

(6) can you be assured that no legal action, or threat of such, will be taken without your consent;

(7) will the agency be governed by your instructions to collect only within the scope of good public relations;

(8) will it agree to report cases deserving your special consideration and accept adjustment, withdrawal or cancellation of an account when, in your opinion, such action is advisable in the interest of good public relations.

If these standards cannot be met by a local agency, it is better not to use any collection service at all. Money collected on bad accounts through the tactics of the unscrupulous and hard-boiled collection agency is a poor offset against the loss of good will for the individual doctor and the profession in general. It should be remembered, however, that the number of accounts requiring collection agency attention can be reduced materially, probably 50% or more, by proper attention to the doctor's accounts receivable problem in his own office.

Medical Society Aids In Presenting Classes For Mothers-to-Be

Sparta, Sept. 11—The Monroe County Medical Society is cooperating in the presentation of a series of classes for expectant and new mothers which started this month.

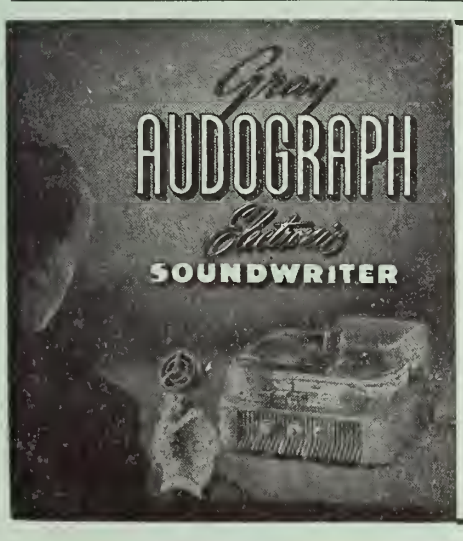
Classes will be conducted by Miss Emily Streich, R. N. assistant public health nurse, with the assistance of Miss Beata Geiger, R.N., and Sister Evarista, obstetrical supervisor of St. Mary's hospital in Sparta.

Large Audience

Highlights of the classes will be a tour of the maternity section of the hospital, demonstrations of bathing, dressing and feeding the baby, a rehearsal of the mothers role during the birth of her baby, instructions of sewing or knitting and special showings of new movies on child birth and child care.

Any expectant mothers or those with young children are invited to attend the classes. Military as well as civilian mothers are invited.

The Medical Society reports that similar classes held at Tomah proved to be interesting and stimulating and drew a large audience.



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IKE SAYS NATIONAL HEALTH INSURANCE WOULD BE "FOOLISH EXPERIMENT"

New York, Sept. 14—The Republican presidential nominee Dwight Eisenhower has taken an emphatic stand against "socialized medicine" as leading toward "assembly line treatment" of patients.

Speaking from his headquarters shortly before starting a campaign tour, Eisenhower said that a patient under federally-operated medical care would suffer as a taxpayer because "it would require a whole new army of government clerks to handle the records that would be an essential part of a compulsory system."

Eisenhower said he recognized that local state and federal government had a responsibility to "assist the unfortunate but it must not be in ways that will lessen or weaken the benefit already available to the vast majority."

"We must not, in providing for the few, wreck the system under which so many can obtain adequate care," he said.

Eisenhower said: "Any move toward socialized medicine is sure to have one result—instead of the patient getting more and better medical care for less, he will get less and poorer medical care for more."

Commenting that he had received many requests for comment on the health insurance plank of the Republican platform, Eisenhower said "I am opposed to a federally operated and controlled system of medical care which is what the administrations compulsory health insurance scheme is, in fact.

"It would destroy things that are essential to high grade medical service. For instance we must preserve the completely voluntary relationship between doctor and patient.

"This means that there must be no intermediary—and that is what the government becomes if the doctors get paid, not by the patient but by the government.

Eisenhower said that the progress of American medicine has been achieved because doctors and scientists had their hearts in their work, doing what they wanted to do and not what they were compelled to do.

"They had the incentive," Eisenhower declared, "to constantly improve themselves, in order to rise in their own profession and to make a better living. These incentives would disappear under government bureaucratic control, because promotion and increased compensation for most doctors would come more by seniority than by merit."

Concluding, the candidate said:

"Experience has shown that American medicine outstripped the world on a voluntary basis, and on that basis—plus voluntary insurance plans, together with locally administered indigent medical care programs for those unable to participate—the needs of Americans will be most adequately met."

Dr. Gundersen Attends World Medical Meeting

Chicago, Sept. 18—Doctor Gunnar Gundersen, La Crosse and Doctor Edwin S. Hamilton, Kankakee, Ill., both trustees of the American Medical Association, will attend the sixth general assembly of the World Medical Association to be held in Athens, Greece, October 11–17.

While much of the time of the assembly will be devoted to the presentation and discussion of medical problems throughout the world, there also will be a scientific program which will include discussions by the world's outstanding authorities on antibiotic therapy, anemias, tuberculosis and diseases of the lung. The last day of the meeting has been set aside for the annual session of medical editors of the world.

Israel Has Many M.D.s But Few in Rural Areas

Chicago, Sept. 30.—Israel has the highest ratio of physicians to population of any county in the world (1 to 495), but it still has the same problem as the United States in getting physicians to practice in rural areas. The U.S. ratio is 1 to 730.

More Hospitals, Too

Joseph Burg, Ph.D., Irsael's Minister of Health, visiting this county in connection with the Israel bond drive, listed among his nation's health problems the need for more doctors in the agricultural settlements.

The AMA has been working in this field in U.S. since 1945.

Dr. Burg said other medical needs include more hospitals and hospital equipment and medical education for immigrants from backward countries.

21 Physicians Named to Committee Posts

Milwaukee, Oct. 8.—Dr. J. C. Griffith, new president of the State Medical Society, appointed 21 physicians to committee posts for the coming year. The appointments were made to fill vacancies created by resignation or expiration of terms of office.

The following appointments were announced by Dr. Griffith:

Cancer:
- Dr. A. R. Curreri, Madison, chairman
- Dr. R. B. Larsen, Wausau
- Dr. K. G. Pinegar, Marinette
- Dr. James Conley, Milwaukee

Coordination of Medical Services:
- Dr. S. B. Harper, Madison, chairman
- Dr. John Wilkinson, Sheboygan

Grievances:
- Dr. R. E. Fitzgerald, Milwaukee, chairman
- Dr. F. A. Nause, Sheboygan
- Dr. H. W. Wirka, Madison

Hospital Relations:
- Dr. K. H. Doege, Marshfield, chairman
- Dr. W. B. Hildebrand, Menasha
- Dr. O. V. Overton, Janesville

Medical Education and Hospitals:
- Dr. T. L. Squier, Milwaukee, chairman
- Dr. A. P. Zlatnik, Two Rivers

Council on Medical Service:
- Dr. D. E. Dorchester, Sturgeon Bay, chairman
- Dr. D. M. Willison, Eau Claire
- Dr. J. S. Devitt, Milwaukee
- Dr. W. J. Fencil, Monroe

Public Policy:
- Dr. James Sullivan, Milwaukee, chairman
- Dr. J. A. Enright, Milwaukee

Council on Scientific Work
- Dr. Maurice G. Rice, Stevens Point

Newer Approaches to Weight Control

As It Looks to the State Board of Health

WEIGHT reduction is a problem with which doctors and dietitians, not to mention patients, have been struggling for years. Innumerable low caloric diet schedules have been devised. Patients have been admonished, coaxed, and threatened in efforts to persuade them to follow a restricted regimen, all too often with disappointing results—they would not stay on the diet long enough to lose sufficient weight, or if they did manage to lose a few pounds, they would revert to former eating habits and regain most of them. Patients on conventional low caloric diets have complained that they were uncomfortably hungry, tired easily, felt restless, became irritable, or were depressed.

Unsuccessful experiences in the management of weight reduction plus the increased concern over obesity have emphasized how inadequately this problem is understood and have led to further investigation. Diet studies have been in progress in a number of nutrition laboratories. One report of particular interest is that of Cederquist and co-workers at Michigan State College[1] on the use of a weight reduction diet in which most of the calories were supplied by protein and fat. The diet averaged 1,400 to 1,500 calories and provided approximately 83 to 93 Gm. of protein, 73 to 87 Gm. of fat and 73 to 96 Gm. of carbohydrates. (Typical menus are outlined in the leaflet "Weight Reduction Through Diet."[2]) Overweight college students were maintained on this diet for approximately 16 weeks, losing on an average 1½ to 2 pounds weekly. This was later applied to adults with similar results. The authors report that without exception this regimen resulted in satisfactory weight loss when subjects adhered to the diet. Subjects consistently reported a feeling of well being and satisfaction. Hunger between meals was not a problem. Weight losses up to 33 kg. did not result in flabbiness or looseness of skin.

At Cornell University, Young has conducted a weight reduction experiment using a diet similar to that of the Michigan group, high protein (90 Gm.), moderate fat (80 Gm.) and low carbohydrate (80 Gm.) Ten students who were 21 to 51 pounds overweight were the subjects. They lost an average of 17 pounds in 8½ weeks, ranging from 1.06 to 2.76 pounds weekly. Young reports that in most cases no hunger was experienced, there was no excessive fatigue, and with the exception of one case of emotional disturbance there was no tendency to regress. Since the fat content of this diet is somewhat higher than in conventional low caloric diets it may be of interest to note that the fasting cholesterol and lipid values were reported to be in normal range at the end of the reduction period for all but one subject.[3,4]

Other factors of special significance in weight control are emotional problems, social customs, and habit patterns. Emotional difficulties often are the basic cause of obesity, and suitable therapy needs to accompany or precede diet instruction. While emphasizing the importance of psychologic aspects of obesity, care should be taken not to overlook the more commonplace problems which may influence the patient, as social situations which lead to unsound food practices or limited funds with which to purchase food. More attention also should be given to the establishment of habit patterns which will not lead to the accumulation of excess fat. Jolliffe[5] suggests that habit exerts a strong influence on appetite and total food intake.

The group approach to weight control has been used with considerable success in various parts of the country. Groups usually are organized under the auspices of a local health agency or center with approval of the local medical organization. The members are obese individuals who desire to lose weight and who feel that they can benefit from group support. They are under the care of a physician who approves their membership in the group. Public interest in group therapy is evidenced in the deluge of applicants for admission whenever a new group is organized. In some areas of Wisconsin individuals interested in weight reduction have organized voluntarily. Many of the members have no medical guidance and are easy prey for diet faddists and peddlers of reducing remedies. They have a problem, they are interested in getting help, and their need should be a challenge to local medical groups and health agencies.—LUCILE K. BILLINGTON, M.S., *Supervisor, Nutrition Division.*

Note: A 16 mm. colored film "Weight Reduction Through Diet" which describes the Michigan State College Weight Reduction Diet experiment is available to local medical societies and hospital medical staffs on request to the State Board of Health (or direct from the Dairy Council in Milwaukee). A sample leaflet containing the diet and menus also is available.

REFERENCES

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Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

Antabuse and Alcoholism

A common pitfall in the clinical application of many new drugs is the false impression that they are curatives rather than therapeutic adjuncts. The situation becomes especially bad when these agents are potentially toxic. *Antabuse* (tetraethylthiuram disulfide, disulfiram) can be discussed with profit from both standpoints.

Tetraethylthiuram disulfide and closely related compounds have been employed for some years as agricultural fungicides and as catalysts in the rubber industry. The attention of the medical profession was focused on *Antabuse* as a result of the chance observation by Danish investigators that ingestion of alcohol, following oral administration of this drug, resulted in a syndrome of characteristic unpleasant reactions. Since then, *Antabuse* or disulfiram (the generic name adopted for tetraethylthiuram disulfide by the World Health Organization for inclusion in the International Pharmacopeia) has been employed in the Scandinavian countries as an adjunct in the psychotherapeutic management of the chronic alcoholic.

Disulfiram does not interfere with the disappearance of alcohol from the blood stream.[1] However, when alcohol is taken after this drug, considerably more acetaldehyde is found in the blood than after ingestion of the same amount of alcohol without disulfiram. The extremely unpleasant symptoms arising from such a drug combination are well correlated with the blood levels of acetaldehyde and may be reproduced by intravenous administration of acetaldehyde to subjects who have received no disulfiram.[2] The inference is that the alcohol-*Antabuse* syndrome is the result of inhibition of metabolism of the acetaldehyde which arises from the oxidation of alcohol.[3] *In vitro* experiments indicate that the predominant action of disulfiram is on liver xanthine oxidase, an enzyme known to metabolize acetaldehyde.

The intensity and duration of the alcohol-*Antabuse* syndrome will depend on several factors, e.g., dosage of disulfiram, amount of alcohol ingested, and individual response. The symptoms and signs consist of flushing, sweating, palpitation, dyspnea, hyperventilation, tachycardia, hypotension, nausea, and vomiting. These symptoms and signs usually appear within 5 to 15 minutes following ingestion of alcohol and are terminated by drowsiness, sleep, and full recovery. Unpleasant effects may follow use of very small amounts of alcohol. Even the application of an after-shave lotion, containing approximately 50 per cent alcohol, has been reported to have produced mild reactions in two patients receiving disulfiram.[4]

The place of disulfiram in the therapy of chronic alcoholism has been brought to the attention of the practicing physician a number of times. Nevertheless, the idea probably still persists in the minds of many that this agent is the answer to the problem of chronic alcoholism. As was so well stated in a recent report of the Council on Pharmacy and Chemistry,[5] "disulfiram alone cannot be expected to remove the underlying maladjustment." Disulfiram may function as a deterrent to the use of alcohol while a sincere effort is being made to remove the underlying desire for alcohol. Glud,[6] on the basis of observations on 10,000 alcoholics receiving disulfiram, emphasizes the need for psychotherapy in the form of group therapy, e.g., Alcoholics Anonymous, and "close liaison between physician, relatives, friends, and social agencies." The success of disulfiram in the absence of other therapy is difficult to determine, but the available figures are not too promising. Without formal psychotherapy Shaw[7] has reported failure with disulfiram in over 80 per cent of the cases studied.

One merely has to recall the early history of such drugs as aminopyrine and the sulfonamides to realize that indiscriminate use of any new drug is to be condemned. Disulfiram is no exception. Innumerable toxic reactions and several deaths have been attributed to the use of disulfiram alone or in combination with alcohol. Toxic reactions may range from drowsiness, fatigability, impotence, headache, and peripheral neuritis to psychoses and hemiplegia. To the writer's knowledge, no deaths have followed the use of disulfiram itself when employed at the recommended dose level. However, extremely severe reactions (usually cardiovascular) and deaths have been reported as a result of ingestion of alcohol by human subjects receiving *Antabuse*.

It is well to continually bear in mind that disulfiram, like any new drug, has definite limitations, is potentially toxic, and may be lethal under certain circumstances. Physicians who are unwilling to acquaint themselves with the indications and dangers of the drug should not prescribe it. Patients who are unwilling or unable to cooperate should not be treated with the drug. If a sincere desire to stop drinking is not established, the drug offers little hope for cure.—F. E. SHIDEMAN, M.D., *Professor of Pharmacology and Toxicology, University of Wisconsin. (Introduced by* A. L. TATUM, M.D.)

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SCHEDULE OF PROGRAMS OF THE "MARCH OF MEDICINE"

On April 1, 1952, the March of Medicine began its seventh consecutive year of radio broadcasting. The programs, which are tape recorded, feature Dr. R. C. Parkin discussing various health problems with a lay person who is called "Your Medical Reporter." At present 32 stations in Wisconsin, one in Michigan, and one in Minnesota are cooperating in presenting this program as a public service feature. The most recent schedule is as follows:

Station	*City*	*Time*	
WHBY	Appleton	Saturday	8:30 a.m.
*WHKW	Chilton	Saturday	10:30 a.m.
*WHWC	Colfax	Saturday	10:30 a.m.
*WHAD	Delafield	Saturday	10:30 a.m.
WEAU	Eau Claire	Saturday	1:30 p.m.
KFIZ	Fond du Lac	Saturday	8:30 a.m.
WBAY	Green Bay	Saturday	5:45 p.m.
*WHLA	Holmen	Saturday	10:30 a.m.
WJMS	Ironwood, Michigan	Saturday	8:15 a.m.
WCLO	Janesville	Saturday	6:30 p.m.
WLIP	Kenosha	Saturday	11:15 a.m.
WKBH	La Crosse	Saturday	11:00 a.m.
WLDY	Ladysmith	Saturday	11:00 a.m.
*WHA	Madison	Saturday	10:30 a.m.
WIBA	Madison	Saturday	9:00 a.m.
WOMT	Manitowoc	Saturday	8:30 a.m.
WMAM	Marinette	Saturday	11:15 a.m.
WDLB	Marshfield	Saturday	10:45 a.m.
WIGM	Medford	Saturday	11:30 a.m.
WEMP	Milwaukee	Sunday	8:30 a.m.
WEKZ	Monroe	Friday	2:00 p.m.
WNAM	Neenah	Wednesday	8:30 a.m.
WOSH	Oshkosh	Saturday	11:00 a.m.
WIBU	Poynette	Thursday	2:30 p.m.
KAAA	Red Wing, Minnesota	Monday	9:15 a.m.
WOBT	Rhinelander	Saturday	9:15 a.m.
*WHRM	Rib Mountain	Saturday	10:30 a.m.
WJMC	Rice Lake	Saturday	10:00 a.m.
WRCO	Richland Center	Wednesday	3:45 p.m.
WHBL	Sheboygan	Sunday	1:00 p.m.
*WLBL	Stevens Point	Saturday	10:30 a.m.
WDOR	Sturgeon Bay	Thursday	9:15 a.m.
WDSM	Superior	Sunday	10:00 a.m.
WSAU	Wausau	Monday	4:15 p.m.

* These stations also carry programs at 7:00 p.m. on Wednesdays on FM only.

Facts about

Blue Shield of Wisconsin

an agency of the State Medical Society of Wisconsin

Prepared by the Commission on Prepaid Plans of the State Medical Society of Wisconsin, E. M. Dessloch, Prairie du Chien, Chairman.

Physicians Service Report (PSR)

From time to time this page has referred to the PSR—an intra-office abbreviation for the "Physicians Service Report." This form is the usual basis for processing a claim under Blue Shield of Wisconsin. With the change-over to the new Blue Shield plan, efforts have been made to develop a new and improved Physicians Service Report.

Various trial forms have been in use for two months in several areas of the state, and starting the latter part of September the new PSR was sent to physicians throughout the state.

The new PSR has three sections. The top portion is clearly marked "to be completed by subscriber or dependent." The center section is to be completed by the physician. A small box in the lower right hand corner is solely for statistical purposes within the Blue Shield office and should be left completely blank.

While the top portion of the new PSR is to be completed by the subscriber or dependent, the information it requests is primarily for the use of the physician. With the exception of the patient's name, group number, contract number and code, the information is not necessary for Blue Shield to complete processing of a claim.

As an example, Item 7 of the PSR requests information about the patient's income status. Space is provided for the patient to indicate his "total income for the past 12 months for everyone on your membership." This information is for the convenience of the physician in determining the income of the patient and thus his eligibility for the full payment features of the Blue Shield plan.

In Item 10, the patient is to answer "yes" or "no" to the question "Other Health Insurance?" The physician will find the answer to this question important because the individual who has other health insurance policies providing coverage for the same services is not entitled to the "full payment" provisions of the contract. The Blue Shield contract states:

> **"Where the participant, at the time services are rendered, is entitled to receive like, although not necessarily equal, benefits under another insurance or service contract, the full payment provision does not apply."**

Blue Shield does not insist that the PSR be signed by the policyholder or participant. The claim will be processed without this signature. However, many physicians find it advantageous to obtain the patient's signature as a means of attesting the patient's statement concerning his income and thus his eligibility for services under the "full payment" provisions of the contract.

The Blue Shield claims department finds that it is able to provide most prompt attention to PSRs in which the physician has provided complete and detailed information in the section describing the services rendered. Unless this portion is completed accurately it may be necessary to engage in correspondence to clarify the type and extent of services rendered.

The signature of the physician who performed the services is essential to processing of the claim.

Physicians will notice that the new PSR consists of two parts—the original and a second sheet. Please do not detach the strip carbons. Return the entire PSR—including the second sheet.

THE FOURTH ANNUAL SCIENTIFIC MEETING

Wisconsin Chapter

AMERICAN ACADEMY OF GENERAL PRACTICE

★

November 10, 11, 12, 1952

Hotel Loraine

Madison

★

Membership in the Academy is not necessary for participation. All physicians are cordially invited to attend. There will be no registration fee.

MONDAY, NOVEMBER 10

A. M.
10:00 Board of Directors Meeting
P. M.
12:30 Luncheon
P. M.
2:00 House of Delegates Meeting
6:00 Dinner and planned entertainment at Hoffman House, Madison

(These are open meetings and all members of the Wisconsin Academy of General Practice are invited to attend both sessions and the dinner.)

TUESDAY, NOVEMBER 11

Crystal Ballroom, Hotel Loraine

Moderator: M. T. Morrison, M. D., Mount Horeb

A. M.
8:00 Registration
9:00 Address of Welcome—J. A. Grab, M. D., Sun Prairie, President, Madison Area Academy of General Practice
9:15 **Headaches:** Francis Millen, M. D., clinical instructor in neurology, Marquette University School of Medicine, Milwaukee
9:45 **Contact Dermatitis—Diagnosis and Treatment:** G. A. Cooper, M. D., assistant professor of dermatology, University of Wisconsin Medical School, Madison
A. M.
10:15 Recess to view exhibits
10:45 **Toxemias of Pregnancy:** Roger S. Siddall, M. D., assistant professor of clinical obstetrics and gynecology, Wayne University College of Medicine, Detroit
11:15 Question period and discussion of the morning presentations
12:00 Lunch in Main Dining Room (125 can be served)

Moderator: L. D. Sobush, M. D., Manitowoc

P. M.

1:30 **Common Orthopedic Problems:** Eugene J. Nordby, M. D., Madison

2:00 **Postgraduate Education Circuit Programs in Wisconsin:** J. W. Gale, M. D., Madison, chairman, Coordinating Committee on Postgraduate Education of the State Medical Society of Wisconsin

2:15 **Androgens and Their Clinical Application:** Cyril M. MacBryde, M. D., assistant professor of clinical medicine, Washington University School of Medicine, St. Louis

2:45 Recess to view exhibits

3:15 **Cancer of the Large Bowel:** Peter Rosi, M. D., assistant professor of surgery, Northwestern University Medical School, Chicago

3:45 **The Adolescent Child:** Thomas W. Geppert, M. D., Dean Clinic, Madison

4:15 Question period and discussion of afternoon presentations

WEDNESDAY, NOVEMBER 12

Crystal Ballroom, Hotel Loraine

Moderator: Joseph C. Griffith, M. D., Milwaukee

A. M.

9:00 **Services Available at the State Laboratory of Hygiene:** Walter H. Jaeschke, M. D., professor of clinical pathology, University of Wisconsin Medical School, Madison

9:30 **Indications and Contraindications for Vein Stripping:** T. T. Myers, M. D., department of vein surgery, Mayo Clinic, Rochester, Minn.

10:00 Recess to view exhibits

10:30 **Acute Cardiac Emergencies:** William S. Middleton, M. D., Dean, University of Wisconsin Medical School, Madison

11:00 **The Physician Witness:** Francis J. Wilcox, attorney, Eau Claire

11:30 Question and answer period of the morning presentations

12:00 Lunch in Main Dining Room (125 can be served)

Moderator: L. V. Sprague, M. D., Madison

P. M.

1:30 **Menopausal Bleeding:** George C. Hank, M. D., Madison

2:00 **Office Proctoscopy:** G. Stanley Custer, M. D., Marshfield Clinic, Marshfield

P. M.

2:30 **Carcinoma of Breast:** James G. Garland, M. D., Milwaukee

3:00 Recess to view exhibits

3:30 **Diagnosis and Management of Carcinoma of the Uterus:** J. H. Randall, M. D., professor of obstetrics and gynecology, State University of Iowa College of Medicine, Iowa City

4:00 Panel discussion on presentations of the afternoon, with special emphasis on carcinoma
Moderator: E. F. Schneiders, M. D., Dean Clinic, Madison
Discussants: Doctors Hank, Custer, Garland, and Randall

ANNUAL BANQUET

6:00 Social Hour: Main Dining Room, Hotel Loraine

6:45 Banquet: Crystal Ballroom
Toastmaster: W. B. Hildebrand, M. D., Menasha
Guest Speaker: A. J. Carlson, professor emeritus, University of Chicago

(Wives of doctors are especially invited to attend the social hour and banquet. It is planned that the banquet should be over by 9:30 p.m. for the convenience of those from out of town who desire to drive home.)

For the Ladies

Registration and headquarters for the ladies will be at the Hotel Loraine. Transportation to all functions will be furnished from there.

Tuesday, November 11

Luncheon at 12:15

Old Madison Room
University of Wisconsin Memorial Union
770 Langdon Street

Program: "Footloose in Europe"
Louise Marston, Society Editor
Wisconsin State Journal

Wednesday, November 12

Luncheon at 1:00 (Social Hour at 12:30)

Blackhawk Country Club
Shorewood Hills

Program: Style Show
MacNeil and Moore
Madison

Dr. Joseph C. Griffith, new president of the State Medical Society, was born in Oconomowoc on November 10, 1898. He received his pre-medical training at Marquette University and then, before returning to Marquette for his medical degree, served as a second lieutenant in the infantry during World War I. He interned at Milwaukee County Hospital and has practiced in Milwaukee since then. He has also done postgraduate study in surgery.

A past president of the Medical Society of Milwaukee County, Doctor Griffith is a member of the Board of Directors of his Society and has also served as a delegate to the State Medical Society. He formerly was on the staff of Marquette University School of Medicine and Milwaukee County Hospital and at present is a staff member of St. Mary's and Misericordia Hospitals.

In addition to the county, state, and national societies, the doctor holds membership in the Milwaukee Academy of Medicine and the Society of Industrial Physicians and Surgeons.

COMMITTEE *Concentrates*

Because of the conclusion of committee activities in anticipation of the House of Delegates meeting there were relatively few formal committee meetings during August and September, though many related activities were carried on which in many cases had bearing upon committee function. It is anticipated that the formation of new committees will be completed within the coming month and formal meetings arranged, which will be reported in subsequent issues of the Journal.

The last report on committee activities, as summarized in the August Journal, covered the period ending on July 31, and this report covers the intervening period, up to the time of the Annual Meeting.

CLAIMS COMMITTEE AUGUST 13

MDs Present: C. C. Reznichek, J. T. Sprague, N. A. Hill, R. C. Parkin.

As reported in other issues of the Journal, the primary function of this committee is to review claims under the insurance programs and determine payments of unscheduled items or contested claims. The determinations are reported to the Commission on Prepaid Plans.

COMMITTEE ON TUBERCULOSIS AND CHEST DISEASES AUGUST 14

MDs Present: John Steele, Henry Anderson, W. T. Clark, A. A. Pleyte, C. N. Neupert, Harold Coon.

Purpose of meeting to discuss with representative of State Sanatoria Trustees Association problems relating to overall costs to patients referred to University Hospitals, Madison, and possibility of handling cases in some manner so that those served through the surgical department at University Hospitals might have all or part of their expenses paid for under some modification of the free care law. Discussion directed to extent of services needed and possibility of expanding surgical facilities at State Sanatorium, or using it as a referral agency, so that those patients referred through that source might have the benefit of free care, in whole or in part . . . . State Board of Health agreed to discuss matter with authorities at Wisconsin General Hospital, and a study to be made as to the possibilities of using State Sanatorium as a referral agency.

EXECUTIVE COMMITTEE COMMISSION ON PREPAID PLANS AUGUST 23

MDs Present: E. M. Dessloch, chairman; Robert Krohn, H. E. Kasten, J. S. Supernaw, A. H. Heidner

General review of problems confronting various programs . . . . report of 11 Wisconsin Plan Companies who have agreed to pay an annual claims and service charge, which will cover the costs of the program to the SMS . . . . Meeting with anesthesiologists to consider revisions in the programs in respect to benefits in that field. . . . . Set up claims administrative procedure where a participating and a non-participating physician have claims for services on a single case. . . . . Approved recommendation that present Price–Taylor plan be discontinued as of Oct. 1, 1952 and a new program, based on WPS schedules with benefits and premiums adjusted to meet the particular needs of those participating in the present program, be offered and that the SMS develop a system of postpayment of premiums, without interest, for those insured who cannot furnish advance premiums. Only office calls to be provided in the revised program. . . . .

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INTERIM COMMITTEE SEPTEMBER 6

MDs Present: A. H. Heidner, R. G. Arveson, J. C. Griffith, J. M. Bell, S. E. Gavin, W. D. Stovall, H. K. Tenney, J. S. Hirschboeck, W. S. Middleton

Primary consideration given to building program and attitude of city officials toward various proposed plans of expanding existing facilities in Society Headquarters. Meeting with mayor and city planning engineer provided basis for alternate plans which are being studied, and will have been reported to the House of Delegates by the time this report is printed. . . . . Authority given to exercise option on purchase of adjoining lake property, so that expansion in present location possible, and additional authority granted to secure option on other property which might be used for building purposes. . . . . Discussed with deans of two medical schools the financial problems of medical schools and to what extent there is need for support through the American Medical Education Foundation . . . . recommended that efforts be made to secure support of all members on a voluntary basis, with donations clearly earmarked for support of either Marquette or the University of Wisconsin. . . . . Approved draft of resolution to be offered the House, outlining powers and limitations of an Executive Committee, to take the place of the Interim Committee. . . . . Also approved proposal to offer House a plan for creation of a Council on State Departments to coordinate many present committees, and to create others.

COMMISSION ON PREPAID PLANS SEPTEMBER 13–14

MDs Present: E. M. Dessloch, Robert Krohn, N. A. Hill, J. T. Sprague, T. D. Elbe, H. E. Kasten, R. E. Garrison, K. H. Doege, Milton Finn, C. G. Reznichek, J. S. Supernaw, H. A. Aageson, R. M. Moore, P. B. Mason, Richard Foregger, H. B. Christianson, R. C. Parkin.

Reviewed the Commission report to the House of Delegates . . . . Approved an index to official actions of the Commission, Executive and Claims Committees . . . . Payment of x-rays subsequent to fracture treatment to the contract liability approved . . . . Directed a study with respect to claims for cosmetic surgery . . . . Local anesthesia not payable under prepaid plans . . . . Approved payment of medical care benefits for calendar dates reported on PSR . . . . Recommended to Council discontinuing "experimental" Price–Taylor program and proposed a revised program embodying the full payment concept and following, in general, the structure of WPS, to low income groups, with approval of county medical society . . . . Directed comprehensive study with respect to catastrophic coverage.

COMMITTEE ON MILITARY MEDICAL SERVICE SEPTEMBER 18

MDs Present: F. L. Weston, J. M. Sullivan, O. G. Moland, M. J. Musser.

Major purpose to review status of Priority I and II physicians still carried as "essential" and study means of handling inevitable call-up of Priority III physicians . . . . Some Priority III physicians will probably be called by January or February . . . . Ages up to 42 seem most vulnerable . . . . Youngest to be taken first . . . . Committee looks with disfavor on proposed plan to find Priority IV replacements for Priority I or II MDs located in "essential" positions.

RELATED ACTIVITIES

While formal meetings of committees have been held at a minimum during the 30 day period prior to the Annual Meeting there were many asssociated activities of the staff which will be reported by mere chronologic listing: August 6, Rural Health Conference Executive Committee (to plan regional rural health conferences this fall). . . . . Councilor District Meetings covered by staff: August 7, 5th District, Thiensville; August 9, 11th District, Iron River; September 11, 10th District, Eau Claire; September 16, 9th District, Stevens Point; September 17, 3rd District caucus meeting, Madison; September 23, 5th District caucus meeting, Cassville . . . . September 4, Board of Trustees of Student Loan Fund.

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Ward, E., Slocumb, C. H., Polley, H. F., Lowman, E. W., and Hench, P. S.,
Proc. Staff Meet. Mayo Clin. **26**: 361, Sept. 26, 1951.

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Society Proceedings

Douglas

Dr. John C. Murphy, superintendent of the Middle River Sanatorium, Hawthorne, was host at the September 3 meeting of the Douglas County Medical Society held at the Sanatorium. The guest speaker for the meeting was Dr. Josiah Fuller, a chest surgeon at the Mayo Clinic. His talk, which was illustrated by slides, was entitled "Modern Surgical Concepts of the Treatment of Pulmonary Tuberculosis."

"Presentation of Recent Case Histories of the Sanatorium, Successfully Treated by Surgery" was the title of a talk by Doctor Murphy, and the surgical aspects of these case histories was discussed by *Dr. Robert C. Jackson* of Superior.

Doctor Jackson, who recently resigned as chest surgeon of the Sanatorium to take postgraduate work at the Mayo Clinic, will be replaced by Doctor Fuller. Doctor Fuller plans to practice in Duluth.

Fond du Lac

F. J. CERNY

The annual business meeting of the Fond du Lac County Medical Society was held at the Elk's Club in Fond du Lac on September 11. Officers elected for the coming year are *Dr. F. J. Cerny*, president, Fond du Lac; *Dr. W. H. Schuler*, vice president, Ripon; *Dr. N. O. Becker*, secretary, Fond du Lac; and *Dr. Josephine N. Pallin*, treasurer, Fond du Lac. *Drs. H. J. Kief* and *J. S. Huebner* were elected delegate and alternate, respectively, to the State Medical Society for terms of two years beginning Jan. 1, 1953.

There were reports by all committee chairmen, and the Society went on record as approving an assessment of $15 per member, the sum of which is to be turned over to the American Red Cross in order to sustain and revitalize the blood procurement program in Fond du Lac. The Society also approved the stand taken by the State Society in backing the proposed Keogh–Reed Bills, and supported the suggestion of having a medical advisor on the staff of all nursing homes and homes for the aged. It was recommended that the city health officer be the official representative.

Price–Taylor

Dr. G. B. Benson, who was recently appointed chief of physical medicine at the Veterans Administration Hospital in Madison, was the guest speaker at the September 13 meeting of the Price-Taylor County Medical Society. Speaking before the members at the high school in Phillips, Doctor Benson chose "Physical Medicine in General Practice" as the subject of his address.

Dr. C. E. Zellmer of Antigo, councilor of the thirteenth district, was also a guest at the meeting. He discussed the allocation of State Society dues.

Sauk

The members of the Sauk County Medical Society met on September 9 at the Warren Hotel in Baraboo to hear an address by *Dr. C. N. Neupert*, state health office. Doctor Neupert discussed the public health problem in Sauk County. The other guest at this meeting was Miss Elizabeth Terry, Sauk County public health nurse, who presented her department's program for the coming year.

Trempealeau–Jackson–Buffalo

Meeting at the Club Midway in Independence on August 12, the members of the Trempealeau–Jackson–Buffalo County Medical Society saw a colored sound movie on "Pudenal Block in Obstetrics" which was presented by *Dr. R. L. MacCornack* of Whitehall.

The main subject for the evening was a discussion of welfare fee problems with the heads of the three county welfare departments involved. An attempt is being made to adopt a uniform tri-county welfare fee schedule. A committee of physicians was named to represent the Society in further, more detailed discussions. Committee members are *Drs. B. C. Dockendorff*, Arcadia; *R. L. MacCornack*, Whitehall; *M. O. Bachhuber*, Alma; and *Robert Krohn*, Black River Falls.

Tenth District Medical Society

The Tenth District Medical Society met in Eau Claire on September 11. The morning program and registration were held at Luther Hospital and featured two scientific talks. *Dr. W. L. Coffey, Jr.*, spoke on "Common Mistakes in Cardiac Diagnosis," and *Dr. H. F. Twelmeyer* chose "Indications for and the Results of Surgery in Heart Disease." Both physicians are from Milwaukee.

Following luncheon the meeting reconvened at the Hillcrest Country Club. Speakers and their subjects were as follows: Dr. Alfred Uihlein, Rochester,

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Minn., "Head Injuries;" Dr. W. G. Sauer, Rochester, "Regional Enteritis: Diagnosis and Management;" Doctor Coffey, "Use of Cardiac Drugs;" and *Dr. J. E. Gonce, Jr.*, Madison, "Respiratory Obstruction in Infants and Children."

Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology

Two Chicago physicians, Drs. Noah Fabricant and William F. Hughes, Jr., were the guest speakers at the two day meeting on September 6 and 7 of the Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology. The Society met at Baileys Harbor in Door County. The program was as follows:

Saturday

"Current Trends in Medication of the Ear, Nose, and Throat," Doctor Fabricant

"Repair of Lid Injuries, Including Entropion and Ectropion," Doctor Hughes

Dinner Address: "Amusing Quotations for Doctors and Patients," Doctor Fabricant

Sunday

"Present Day Practice Regarding Orbital Implants after Enucleation," and a movie on "The Technique of Implantation of Buried Polyvinyl Implants," Doctor Hughes

"On Writing Medical Papers," Doctor Fabricant

News Items and Personals

Independence Holds "Doctor Peterson Day"

The *Dr. C. F. Peterson* Day activities, sponsored by the local Lions Club, were held in Independence at the city hall on July 13. Ninety-four Doctor Peterson babies were registered and prizes were given to the oldest, the youngest, the parents of the most Doctor Peterson babies in one family, and the "baby" coming from the longest distance. Among the physician guests present were *Drs. O. M. Schneider*, Blair, *D. R. Peterson*, Strum, and *H. A. Jegi* of Galesville. Judge Grover L. Broadfoot, justice of the State Supreme Court, was the main speaker of the day, and Mr. John A. Markham gave a biographical sketch of Doctor Peterson's life and presented him with a gift of a large leather easy chair.

Doctor Peterson, who is 81 years old, was born in Germany and moved to the United States with his family when he was 13. He quickly mastered the English language and was graduated from Arcadia High School in 1892. He received his County Teachers certificate and served as principal of the Independence, Osceola, and Galesville schools before he decided to study medicine. He received his medical degree from Northwestern University Medical School at Chicago in 1907 and returned to Independence where he has practiced for the past 45 years.

Doctor Kilkenny Accepts Scholarship

Dr. T. E. Kilkenny, who has practiced in Winneconne for the past 10 years, has accepted a fellowship at the Alton Ochsner Medical Foundation at New Orleans. On October 1 he began a three year period of specialized training in orthopedic surgery. The course includes six months of postgraduate study at the Medical School of Tulane University. The doctor does not plan to return to Winneconne but will probably set up his practice in some large city when he completes his training.

Two Doctors Open Office in New Lisbon

Two 1951 University of Wisconsin Medical School graduates, Drs. S. H. Ferguson and Clayton Weston, have opened an office in New Lisbon. Both doctors have recently completed their internships at St. Luke's Hospital in Duluth. They will be on the staff of the Tomah Memorial Hospital, St. Mary's at Sparta, and the Mauston Hospital.

Doctor Cole Has New Associate

Dr. Frank Wright, Jr., a native of Bloomington, Ill., has become associated with *Dr. D. F. Cole* of Ripon in the practice of medicine and surgery. Doctor Wright received his medical degree from the University of Illinois College of Medicine in 1950. He interned at St. Luke's Hospital, Spokane, Wash., and then took a general practice residency at MacNeal Memorial Hospital in Berwyn, Ill.

Menomonie Clinic Has New Staff Member

Dr. Robert J. Gardner, who recently completed his internship at Cook County Hospital, Chicago, joined the staff of the Menomonie Clinic on August 1. He replaced *Dr. G. A. Mann* who resigned in order to specialize in anesthesiology at the Ancker Hospital in St. Paul. Doctor Gardner is a graduate of Northwestern University Medical School and a veteran of the U. S. Navy.

Doctor Weisse Elected to Fellowship

Dr. H. A. Weisse, Plymouth physician, was recently elected to fellowship in the American Academy of Obstetrics and Gynecology. The doctor served his residency at Methodist Hospital, Dallas,

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Surgery of Colon & Rectum, One Week, starting October 20, November 17
Gallbladder Surgery, Ten Hours, starting October 20
Bronchoscopy, One Week, by appointment
General Surgery, One Week, starting October 6
General Surgery, Two Weeks, starting October 6
Breast & Thyroid Surgery, One Week, starting October 6
Esophageal Surgery, One Week, starting October 13
Thoracic Surgery, One Week, starting October 20
Fractures & Traumatic Surgery, Two Weeks, starting October 6
GYNECOLOGY—Intensive Course, Two Weeks, starting October 20
Vaginal Approach to Pelvic Surgery, One Week, starting November 3
OBSTETRICS—Intensive Course, Two Weeks, starting September 29, November 3
MEDICINE—Intensive General Course, Two Weeks, starting October 13
Gastroenterology, Two Weeks, starting October 27
Gastroscopy & Gastroenterology, Two Weeks, starting November 3
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Texas, and more recently completed a year's recall duty with the Naval Reserve at the USN Infirmary, Monterey, California and the USA Hospital, Fort Ord, California.

Doctor Weisse and his partner, *Dr. Lloyd J. Steffan*, began their practice together in Plymouth following their discharge from the Navy after World War II.

New Physician to Practice in Bloomington

Dr. W. S. Cusick, a graduate of Loyola University School of Medicine, opened an office in the village of Bloomington on August 1. The doctor has just completed his internship at Mercy Hospital in Chicago. He is a veteran of World War II, and following his army service he attended Loyola University for his pre-medical education.

Doctor Vrabec Joins Staff of Hoyer Clinic

Dr. A. P. Vrabec, a native of Milwaukee, joined the staff of the Hoyer Clinic in Beaver Dam during July. He is a graduate of the University of Wisconsin Medical School and served his internship at St. Agnes Hospital at Fond du Lac.

Ladysmith Has New Physician

Dr. R. P. Bennett of West Bend is now associated with *Dr. Woodruff Smith* in the practice of medicine and surgery at Ladysmith. Doctor Bennett was graduated from the University of Wisconsin Medical School in 1951 and served his internship at the University of Kansas Medical Center. The doctor also plans to practice two days a week in Hawkins.

Doctor Canavan Honored

The first issue of "The Wisconsin Family Physician," a new publication of the Wisconsin Academy of General Practice, is dedicated to *Dr. J. P. Canavan*, Neenah general practitioner. Doctor Canavan, a physician for more than 35 years, was founder and first president of the group that was granted the charter for the Wisconsin chapter, which is now the sixth largest chapter in the country.

Two Doctors Join Staff of Gosin Clinic

The association of *Dr. Harry H. Danaher* and Dr. Edward F. Daley with the Gosin Clinic in Green Bay was recently announced. Doctor Danaher is a graduate of Marquette University School of Medicine. He served in the Medical Corps of the U. S. Air Force before returning to Milwaukee County Hospital as chief resident surgeon.

Doctor Daley, a native of Green Bay, received his medical degree from St. Louis University School of Medicine, and during the past year served his internship at Milwaukee County Hospital.

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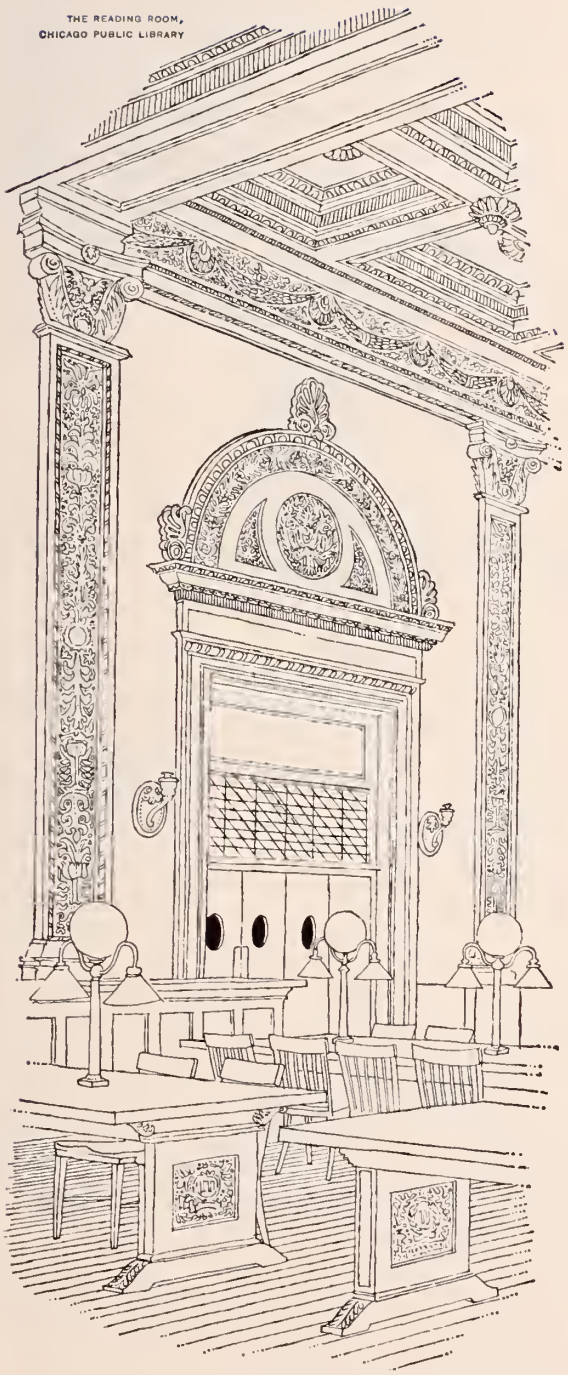

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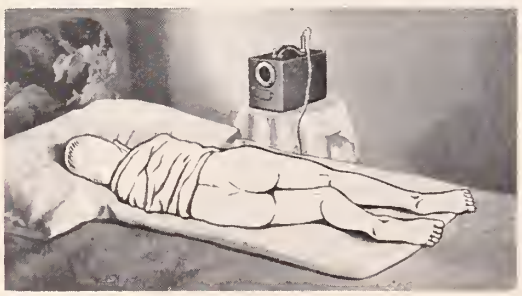

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THIRD AND TWELFTH DISTRICT NEWS

A. S. Jackson Honored by Surgeons

A. S. JACKSON

Dr. Arnold S. Jackson, chief of staff of the Jackson Clinic and Methodist Hospital, Madison, was elected president of the United States Chapter of the International College of Surgeons at a meeting of the College in Chicago on September 2. He was previously secretary of the chapter.

Among other Madison physicians who attended the meeting were *Drs. W. B. Hobbins, L. E. Holmgren, J. T. Sprague, J. R. Steeper* and *G. H. Ewell,* who was one of the speakers.

Physician Joins Dells Clinic Staff

Dr. G. B. Ellenz, a graduate of Loyola University School of Medicine, has joined the staff of the Dells Clinic in Wisconsin Dells. A veteran of World War II, the doctor recently completed his internship at La Crosse Lutheran Hospital.

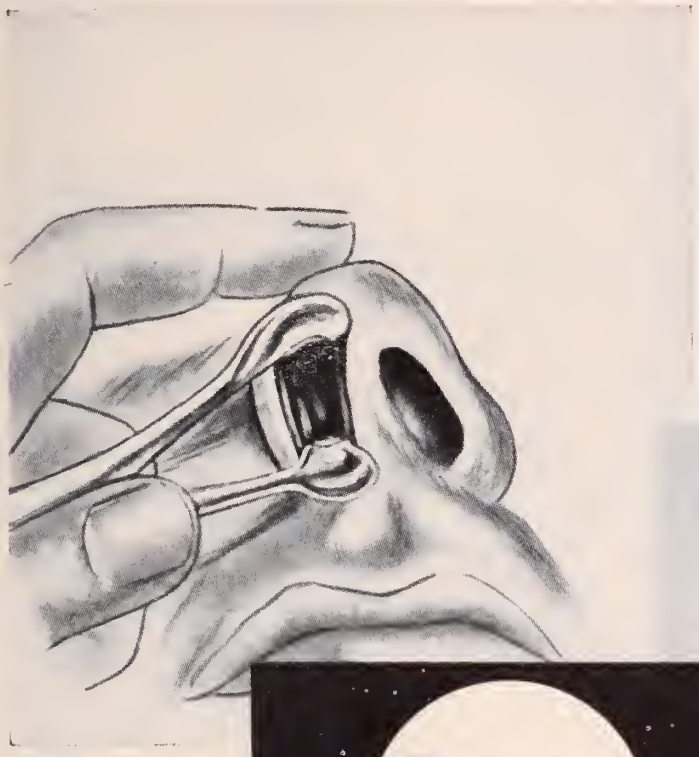
Doctor Lyons Starts Practice in Radiology

Dr. Robert P. Lyons, who has been a resident in radiology at the Jackson Clinic for the past two years, has become associated with *Dr. L. V. Littig* in the practice of radiology in Madison. Doctor Lyons is a graduate of Loyola University School of Medicine and served his internship at Mercy Hospital in Chicago. He also took a postdoctorate in anatomy at the University of Wisconsin.

Jackson Clinic Has Two New Staff Members

Dr. John H. Flinn, Evansville, Ind., and Dr. Howard W. Mahaffey, Florence, S. C., recently joined the staff of the Jackson Clinic and the Methodist Hospital. Doctor Flinn, a graduate of Northwestern University Medical School, had practiced in Evansville for the past few years and is now associated with the internal medicine department of the Clinic and Hospital.

Doctor Mahaffey, an orthopedic surgeon, served a three year residency in his specialty following his graduation from Ohio State University College of Medicine.



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Chest Surgeon Addresses Madison Physicians

Dr. Evarts A. Graham, nationally known chest surgeon, addressed Madison area physicians on September 12 at the auditorium of the Veterans Administration Hospital in Madison. The Bixby professor emeritus of surgery of Washington University School of Medicine, Doctor Graham chose "Carcinoma of the Lung" as the subject of his talk.

Doctors Kalb and Dean Are New Associates

Dr. C. H. Kalb and *Dr. G. W. Dean* have recently become associates with offices in the Plankinton Building in Milwaukee. Their practice will be limited to allergy and internal medicine.

Doctor Purtell Receives National Appointment

Dr. R. F. Purtell, secretary of the Wisconsin chapter of the American Academy of General Practice, was recently honored by his appointment to the post of chairman of the Committee on Liaison with Blue Shield Medical Care Plans and Medical Insurance of the American Academy. His duties in this position will be to act in a liaison capacity at the national level with the National Blue Shield and Blue Cross committees.

Milwaukee Surgeons Honored

At the recent meeting of the U. S. chapter of the International College of Surgeons held in Chicago, *Dr. E. A. W. Habeck* was given a qualified fellowship in the College. Two other Milwaukee surgeons, *Dr. H. B. Benjamin* and *Dr. E. M. End*, were admitted to the allied science section of the College.

SOCIETY RECORDS

New Members

R. P. Bennett, Ladysmith.

J. H. Noble, 912 Harrison Street, Black River Falls.

Changes in Address

T. V. Geppert, Palo Alto, California, to 4211 Wanetah Trail, Madison.

J. J. McLeod,* Superior, to Box 55, Birchwood.

J. N. Richards, Madison, to Kenosha National Bank Building, Kenosha.

H. L. Eisen, University, Missouri, to 566 West I Street, Ontario, California.

B. J. Haines, Arcadia, to Cadott.

R. C. Thackeray, Racine, to Box H, Winnebago.

T. L. Calvy, Wood, to 208 East Wisconsin Avenue, Milwaukee.

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A. V. Pisciotta, Boston, Massachusetts, to Milwaukee County Hospital, 8700 West Wisconsin Avenue, Milwaukee.

M. Q. Howard, Wauwatosa, to Box 390, Blackfoot, Idaho.

J. W. Frye,* Milwaukee, to United States Army Hospital, Camp Carson, Colorado.

S. A. Korducki, Milwaukee, to City Hospital, 3395 Scranton Road, Cleveland, Ohio.

R. E. Jensen,* Green Bay, to 710 Gulf Road, Waukegan, Illinois.

E. C. Jarvis,* Madison, to United States Air Force, 72nd Air Base Squadron, Woll–Chamberlain Field, Minneapolis, Minnesota.

W. C. Sroka,* APO San Francisco, California, to 3575th Medical Group, Vance Air Force Base, Enid, Oklahoma.

P. J. Lawler, Lewisburg, Pennsylvania, to 9541 West Bluemound Road, Milwaukee.

Richard Minton, Whitefish Bay, to Box O, Gorgas Hospital, ANCAN, Panama Canal Zone.

L. L. Larsen, Fort Hood, Texas, to 11006 West Godsell Avenue, Hales Corners.

W. G. Arnold, Milwaukee, to Clintonville.

P. D. Nelson, Madison, to Post Office Box 6, Norwich State Hospital, Norwich, Connecticut.

N. P. Anderson, La Crosse, to % J. E. Achorn, Box 1163, Crystal River, Florida.

Erich Wisiol, Fort Lauderdale, Florida, to 441 Main Street, Stevens Point.

H. E. Schaefer,* Manitowoc, to United States Air Force, 3882nd Sch. Sq., Gunter Air Force Base, Montgomery, Alabama.

M. S. Le Tellier, Milwaukee, to The Astoria Clinic, 300 Spexarth Building, Astoria, Oregon.

E. L. Baum, Milwaukee, to Box 278, Naples, Florida.

A. F. Rasmussen, Madison, to Department of Infectious Diseases, University of California Medical School, Los Angeles, California.

B. H. Roisum, Dubuque, Iowa, to 15 Mohawk Circle, Madison.

D. D. Sanders, Milwaukee, to Veterans Administration Hospital, Long Beach, California.

* Military service members.

DEATH

Dr. Stanley J. Seeger, a past president of the Medical Society of Milwaukee County (1926) and the State Medical Society of Wisconsin (1934), died at the age of 62 on Friday, June 20, in New York City. We record with deep regret his untimely loss from our membership.

Following his graduation from Marquette University and Northwestern University Medical School, Doctor Seeger received his early postgraduate training at Michael Reese Hospital, Chicago, and later became an assistant in surgery at the Mayo Clinic, Rochester, Minnesota. After serving in the Army Medical Corps in World War I, he entered private practice in Milwaukee where his skill as a surgeon and ability as a leader in medicine was promptly recognized. Our distinguished colleague became chief of staff at Columbia Hospital in 1928 and at Children's Hospital in 1934. Both of these institutions, under his guidance and inspiration, have since become renowned for their postgraduate educational programs and their excellent facilities for the care of the sick. In recognition of his outstanding work, the amphitheater at Milwaukee Children's Hospital was named after him in 1944. Throughout his years of active practice in surgery, Doctor Seeger maintained an open and investigative mind, contributing importantly from time to time to the surgical literature, particularly in the field of traumatic surgery and the management of burns. In 1936 he received a Master's Degree in Anatomy from Marquette University.

Over the years, Doctor Seeger was honored by appointments to many responsible offices—as vice-president of the A.M.A. and chairman of the A.M.A. Council on Industrial Health. He was the guiding spirit in the organization of the Milwaukee County Medical Society under a full time staff and participated in the publication of the first Bulletin of the County Society, now known as the *Milwaukee Medical Times*. He also recognized the need for and established the Physician's Service Bureau of the County Society.

Many local and national medical societies honored him with membership: American College of Surgeons, American Association of Industrial Physicians and Surgeons, American Association for the Surgery of Trauma, Western Surgical Association, Milwaukee Academy of Medicine, and the Milwaukee Surgical Society. He is a Founder's Member of the American Board of Surgery, and was a former president of the Alumni Association of the Mayo Foundation.

While his private practice in surgery was limited because of his self-imposed investigative work and civic obligations, he will long be remembered by his patients for his modesty, his honesty, and integrity. His students and the younger surgeons who worked in his clinics will always be grateful for his untiring interest in their training and education. His colleagues in medicine and surgery will miss his wise counsel and tireless efforts to maintain medical standards at the highest level.—*Prepared for the Journal by Carl W. Eberbach, M. D.*

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All of the current medical journals received by the State Medical Society on an exchange basis, and the medical text books reviewed in *The Journal "Bookshelf,"* are given to the Medical Library Service and then become available to any physician in Wisconsin who indicates his desire to use them. All that is required is for the physician to advise the Medical Library Service that he wishes a loan packet on the specific subject he wishes to study. Packets, for example, may be obtained on: acute appendicitis, treatment of fractures of femur, medical or surgical treatment of ulcers, poisons in industry and many others.

Address as follows: Medical Library Service, Service Memorial Institute Building, North Charter Street, Madison, Wisconsin.

The Physiology and Pathology of Hemostasis. By Armand J. Quick, Ph.D., M.D., professor of biochemistry, Marquette University School of Medicine. With 18 illustrations. Philadelphia, Lea and Febiger, 1951.

This monograph by one of the leading authorities in the field of blood coagulation is principally a statement of the work done by the author and his co-workers. It is, in this sense, a valuable summary of the work in the field of blood coagulation which has come out of his laboratory and will be frequently referred to by anyone particularly interested in this field. Much of the work which Doctor Quick presents has been generally accepted. Some points are still in dispute, and the author makes no serious attempt to reconcile his findings and opinions with those of others. However, what would normally be considered the weakness in a monograph of this type is, in the reviewer's opinion, probably its greatest strength in that it makes available a summary of the author's own ideas and work in a form much easier to present than would be the case if he had attempted to reconcile all the work which has been done in this field.

The first chapter contains an excellent short discussion of the historical development of the concepts of hemostasis. In the second chapter the author presents a unified concept of hemostasis which coordinates all of this experimental work into a scheme which has, in the most part, sound experimental proof. In the third chapter a classification of the hemorrhagic diseases is presented which has a great deal of merit and will probably be of great assistance to any physician who attempts to treat or diagnose one of these diseases. In chapter four the author gives practical suggestions in the handling of hemorrhagic diseases, both medically and surgically. Chapter five contains an excellent discussion of the history, mechanism, and treatment of venous thrombosis.

Part Two comprises about one-half of the monograph and in this part are listed the laboratory methods useful for study of hemorrhagic diseases. The tests are well outlined and the directions are clear and easy to follow. The tests are the ones used in the author's laboratory and again the significance of some of them should be evaluated with this in mind. For example, Test No. 13 is called an "Assay of Thromboplastinogen," in line with the author's views on the deficiency in hemophilia. Actually, it consists of determining the effect of the addition of normal blood to hemophilic blood in various mixtures and only indirectly can this be assumed to be an assay of thromboplastinogen. The method as outlined in the monograph can only measure in a crude way the antihemophilic effect of normal blood.

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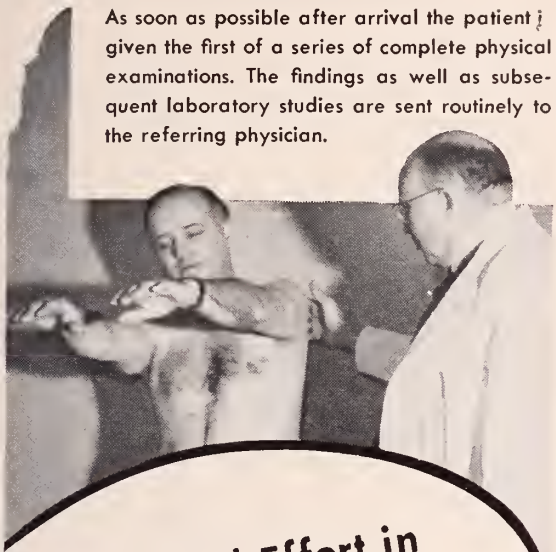

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Migraine In Children

"Migraine may appear during the first years of life. The presence of subjective signs, such as headache and flimmer scotoma, is often difficult to determine in young children. The true nature of the symptoms frequently remains obscure for years."

Vahlquist, B. and Hackzell, G.: Acta Paediatrica *38*: 622 (1949).

NO. OF CASES	SEX	AGE AT ONSET	CYCLIC VOMITING	DURATION OF ATTACK	INTENSITY
31	8 ♀ 23 ♂	3 yrs. (mean)	3 out of 31	2½ hrs.	severe in all cases

TABLE CONT'D

NO. OF CASES	UNILATERAL HEADACHE	NAUSEA	FLIMMER SCOTOMA	VERTIGO	HEREDITY
31	18 out of 31	31 out of 31	12 out of 31	6 out of 31	20 out of 31

(reference given above)

In a study of 400 adult migraine patients, it was revealed that 34% had suffered attacks before the age of 15.* These investigators concluded that childhood migraine was a much greater clinical problem than was previously believed and that psychodynamic mechanisms played an important part in the disease.

These criteria are useful in diagnosis:

Headache attacks with symptom-free intervals plus (at least two of the following) nausea, scintillating scotoma, hemicrania, and hereditary predisposition.

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In the adolescent age group, 12 to 18 years of age, the dosage may gradually be increased as necessary up to the usual adult dose, i.e., two tablets when the attack appears imminent followed by one tablet doses at half hour intervals until the attack is aborted. *(Total maximum dose for adults: six tablets for each attack.)*

*Katz, J., Friedman, A.P., and Gisolfi, A.: New York State J. Med. *50*: 2269 (Oct.) 1950.

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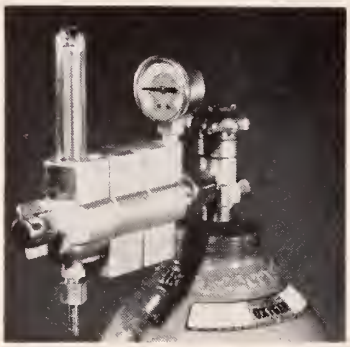

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Nevertheless, this monograph is a valuable addition to the reference library of anyone interested in the hemorrhagic diseases and presents a clear, readable, and well-organized summary of the author's ideas and experience. The author's failure to review the work from other laboratories in detail is not considered a strong drawback since the literature in the field of blood coagulation is voluminous and, in many respects, difficult to correlate. Furthermore, the references at the end of each chapter are fairly representative. This book should receive widespread acceptance by all physicians and will serve as a ready reference to specialists in this field.—J.B.M.

Rheumatic Diseases; Based on the Proceedings of The Seventh International Congress of Rheumatic Diseases. Prepared by the Committee on Publications of the American Rheumatism Association: Charles H. Slocumb, M. D., chairman. Philadelphia and London, W. B. Saunders Company, 1952. Price $12.00.

This book, as the subtitle indicates, is based on the Proceedings of the Seventh International Congress on Rheumatic Diseases which was held in New York City in June of 1949. The contents are composed of abstracts or full length papers which were presented at that meeting and the material is what one might expect to find in a medical journal rather than a textbook.

A wide variety of subjects relating to rheumatic fever and the most common forms of arthritis are presented. The papers range all the way from practical clinical studies to investigative studies of immune reactions, physiologic aspects, and blood plasma in rheumatic diseases.

It was at this meeting that Hench, Kendall, Slocumb, and Polley presented their data on the first patients with rheumatoid arthritis and rheumatic fever treated with Cortisone and ACTH. One of the most striking features of this presentation was the total acceptance by all the discussers of this paper (which included some of the most outstanding rheumatologists in this country) of the results presented without a single word to suggest that perhaps it was a bit early to judge these new drugs and that a period of several years will be necessary before they can be carefully evaluated.

This book is hardly to be recommended as a text but is a good source of recent clinical, investigative, and therapeutic data relating to rheumatic fever and rheumatoid arthritis.—R.Q.

Let's Have Healthy Children—By Adelle Davis, A.B., M.S., consulting nutritionist. New York, Narcourt, Brace & Co., 1951. Price $3.00.

This book presents a discussion of the influence of diet upon the health of infants, young children, and pregnant and nursing women. Although much of it is sound, the material throughout the 22 chapters is characterized by exaggeration—exaggeration of the applicability of the findings of laboratory animal investigation to man, of the benefits derived from optimum nutrition, and of the role played by the in-

dividual nutrients, especially the B vitamins, in human nutrition.

Fortified by the results of the Toronto and Harvard studies, which showed a definite influence of diet upon pregnancy, labor, and the health of the newborn infant, and by Warkany's work showing the relationship between deficiency of vitamins and congenital defects of laboratory animals, the author states, "Most of the complications of pregnancy are related in one way or another to a diet which is not completely adequate. The expectant mother herself usually determines whether she will suffer from few complications or many and whether they will be mild or severe." In order that the ideal nutritional status may be attained, it is recommended that the daily diet during pregnancy, and before conception, include the following: 1 quart of skim milk enriched with ½ cup of powdered skim milk, thereby covering the increased need for protein and calcium; 25,000 units of vitamin A; 3,000 units of vitamin D; 30 mg. alpha tocopherol; tablets of iron and copper; iodine as iodized salt, and, in the goiter belt, Lugol's solution or tablets of potassium iodide; large quantities of the B vitamins in the form of wheat germ, liver, powdered brewer's yeast and yogurt (to promote production of B vitamins in the intestine); a glass of fresh orange or grapefruit juice plus 100 mg. ascorbic acid; and during the last week of pregnancy 5 mg. of vitamin K. The continuation of such a diet after the baby comes will, according to the author, provide the mother with freedom from fatigue and worry,

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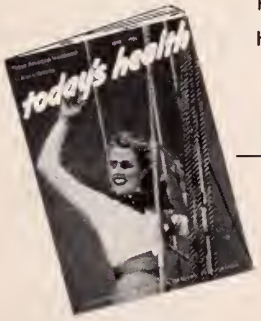

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The recommendations for supplements to be given to both the breast-fed and the artificially fed infant made by the author are in a similar vein to those made for the pregnant woman, with special emphasis upon brewer's yeast for its B vitamins content, and wheat germ oil for its vitamin E and unsaturated fatty acid content. As a result of giving the baby all of the recommended supplements and, in the case of the artifically fed infant using raw certified milk, the baby, according to the author, will grow and develop normally, be free from disorders such as colic, constipation, diaper and other skin rashes, eczema, feeding difficulties, and be beautiful.

Most of the exaggerations found throughout the text have some basis in facts discovered in experimental studies of laboratory animals or man. A typical example is the condemnation of multivatimin capsules, as follows: "Evidence indicates that the taking of any one or more B vitamins increases the need for all the other vitamins of the group. It may be that the B vitamins supplied in multivitamin capsules actually cause the need for such vitamins as B 12 or choline to be increased and that taking such preparations could be a factor in bringing about anemia and toxemia during pregnancy. For this reason, I consider them dangerous and not to be recommended unless foods rich in all the B vitamins are taken with them." The one outstanding example of a statement for which there is no support is as follows: "The sweeter sugars used in infants' formulas cannot be converted into lactic acid. On the contrary, they stimulate the flow of alkaline digestive juices in the intestine. Thus, they probably allow the destruction of certain vitamins and interfere with the absorption of iron, calcium, and phosphorus to such an extent that they can be detrimental to the development of the blood, bones, and teeth. Since these sugars are little needed to produce energy, they are converted into Association for Research in Ophthalmology. Illususeless and unsightly fat."—J.E.G.

Untoward Reactions of Cortisone and ACTH. By Vincent J. Derbes, M. D., F.A.C.P., associate professor of medicine, Tulane University of Louisiana School of Medicine; head of department of allergy, Ochsner Clinic; visiting physician, Charity Hospital of Louisiana at New Orleans; and staff member, Foundation Hospital, New Orleans, Louisiana; and Thomas E. Weiss, M. D., instructor in medicine, Tulane University of Louisiana School of Medicine; member of department of medicine. Ochsner Clinic; visiting physician, Charity Hospital of Louisiana at New Orleans; and staff member Foundation Hospital. New Orleans, Louisiana. Springfield, Illinois, Charles C. Thomas, 1951. Price $2.25.

Now that the initial wave of enthusiasm which attended the introduction of ACTH and cortisone into clinical medicine has passed, it is inevitable that attention should be called to the numerous and often serious side reactions produced by these potent agents. This small book reviews these concisely and well. The main points are summarized at the beginning of each chapter dealing with the side effects on a particular organ or metabolic system. The book

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Textbook of Refraction. By Edwin F. Tait, M. D., Ph.D., associate professor of ophthalmology, Temple University School of Medicine; attending surgeon (ophthalmology), Temple University and Montgomery Hospitals; fellow, Philadelphia College of Physicians, and American Academy of Ophthamology and Otolaryngology; member, The Pan-American Association of Ophthalmology, and The trated. Philadelphia, W. B. Saunders Company, 1951.

In this volume of 418 pages, Professor Tait succeeds in giving us a solid foundation for the study of refractive problems. He begins by reviewing the normal physiology of the eye and the physiological optics concerned in refraction. A discussion of the abnormal functions of seeing is then pursued with special emphasis on refractive errors, muscle anomalies, and the stresses found in binocular vision, methods of studying the refractive errors and their associated problems are described in the last half of the book. Reference is made to the newer visual aids and to orthoptic training, showing the help and limitations each affords.

The book is designed for students and practitioners and is devoid of history, mathematical formulae, and complicated discussion. The language is easily read and readily understood. Each chapter is followed by an up to date bibliography. This book is considered one of the better of the recent additions on the subject of refraction.—P.A.D.

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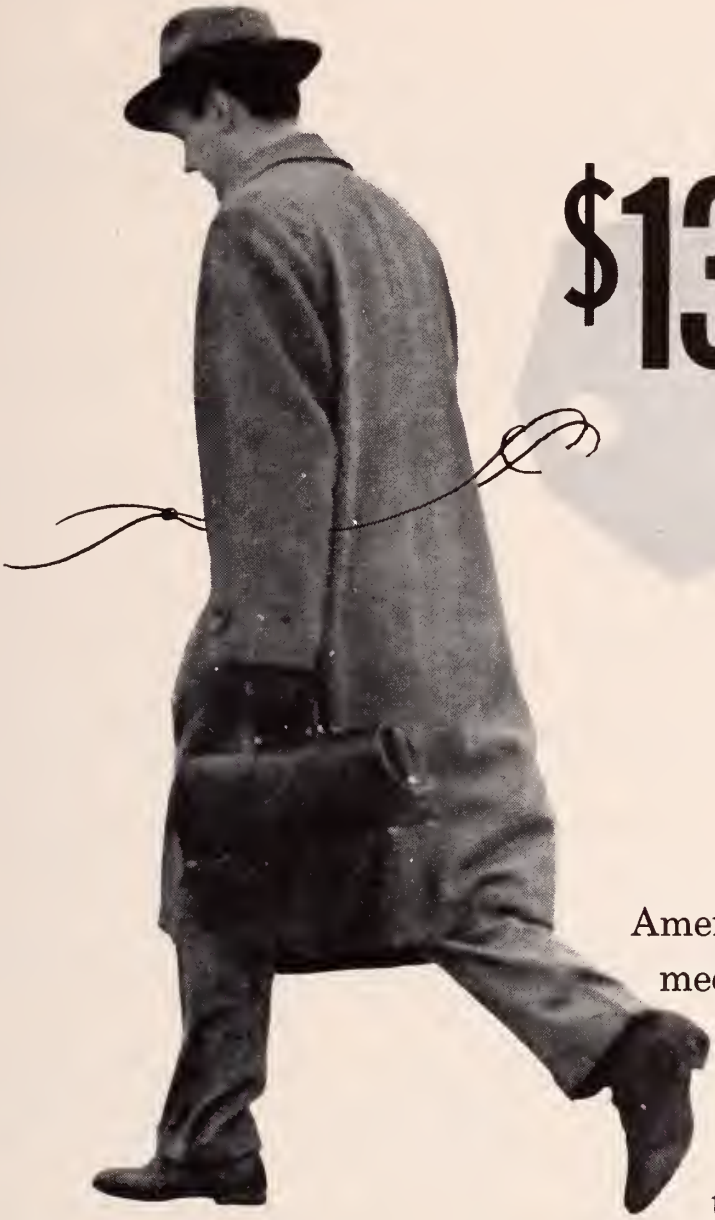

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WANTED: Physician interested in general practice in a small community in Wisconsin, and one who wishes to have at his disposal the latest in diagnostic facilities. Hospital staff appointment assured. Address replies to box No. 425 in care of the Journal.

PHYSICIAN WANTED to associate with a general practitioner in well established practice. Excellent hospital facilities. Address replies to box No. 426 in care of the Journal.

FOR SALE: General practice and equipment for 7 room office in prosperous dairy city of southern Wisconsin. This city of 5,000 has only 3 M.D.s in active practice. Residence available for sale or rental. Address replies to box No. 428 in care of the Journal.

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WANTED: Two physicians to buy a fully equipped clinic which is servicing an area containing 11,000 persons in north central Wisconsin. Liberal terms can be arranged. Address replies to box No. 436 in care of the Journal.

WANTED: Obstetrician, certified or Board qualified, for young progressive Wisconsin Group. Excellent chances for development. Address replies to box 453 in care of the Journal.

PHYSICIAN WANTED: Assistant wanted in a general practice which includes a liberal amount of major surgery. This is in a well established modern office in a city of about 35,000 in central Wisconsin. Salary to start and early partnership hoped for. Address replies to No. 439 in care of the Journal.

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FOR SALE: Country practice with no competition. Only buy modern residence, with office and waiting room in residence—separate office entrance. Office in residence saves you office rent, phone, and secretary expense. Beautiful surroundings. Address replies to No. 440 in care of the Journal.

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WANTED: Midwest group of 20 physicians have opening for an assistant in general surgery including traumatic, industrial, and minor injuries; liberal salary depending upon experience or previous training. Address replies to box 454 in care of the Journal.

PHYSICIAN WANTED, preferably out of internship, for general practice. Attractive salary and chance for partnership affiliation. New office building, good equipment, time off—good hunting and fishing. Address replies to box 421 in care of the Journal.

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LCAN MEDICAL ASSOCIATION news notes OCTOBER, 1952

AMA news written especially for use in state medical journals

TV Shows to Highlight Denver Meeting

Plans are being made to present two half-hour network television shows covering high points of the American Medical Association's sixth annual Clinical Session in December. Originating from Denver, the telecasts will highlight Session activities, including presentations of new surgical and clinical demonstrations, special scientific exhibits and other interesting medical features. The programs will be of interest to physicians who cannot attend the meeting as well as to the general public.

Present plans call for coast-to-coast coverage on two different nights during the meeting, December 2–5. Once again the programs are being sponsored by Smith, Kline and French, Philadelphia pharmaceutical firm.

Rural Health Conference Set for February 27–28

"Widening the Highway to Health" will be the theme of the eighth national Conference on Rural Health to be held February 27–28 at the Roanoke Hotel, Roanoke, Virginia. The day preceding the general sessions (February 26) will be devoted to an informal get-together of physicians, who are responsible for rural health programs in their respective states, to discuss "Doctor Participation in Community Programs."

The subject of financing rural medical care will be covered at Friday's sessions. An experience-and-accomplishment program to stimulate thought on "What Can *I* Do When I Get Home?" will be presented the last morning. The final luncheon speaker will tell what medicine is doing, in cooperation with other organizations and groups, to help America solve its health problems.

New Radio Series on Sports and Health

A new series of radio transcriptions dealing with sports and health subjects will be available about December 15 from the AMA's Bureau of Health Education for use by local radio stations. The programs are based upon on-the-scene interviews with Olympic winners in Helsinki, Finland, and with national champions and other outstanding sports figures in this country.

Topics cover personal aspects, athletic accomplishments, team practice and health values of sports. Among those interviewed were Bobby Brown, M.D., of the world's champion New York Yankees; Harrison Dillard, Olympic 100-meter hurdling champion, and Julius Boros, world's national golf champion.

PR Conference in Denver

The AMA's fifth annual National Medical Public Relations Conference will be held Monday, December 1—the day before the opening of the Clinical Session—at the Shirley–Savoy Hotel, Denver. Theme of the one-day meeting will be "Mutual Understanding . . . the Key to Better PR." The Conference program will be geared primarily for physicians. Members of the House of Delegates, officers of state and county medical societies, officers of the Association and executive secretaries and PR personnel are cordially invited.

Rural Health Radio Series Available

An eight-week radio transcription series on rural health entitled "Help Yourself to Health" will be released October 15 by the AMA's Bureau of Health Education to state and county medical societies. The series consists largely of true stories about small American communities which have successfully solved their health problems through local initiative and effort. Citizens from these communities tell the stories in their own words.

Verbatim comments used in the transcriptions were tape-recorded at the National Conference on Rural Health held in Denver. The series was produced by the Rocky Mountain Radio Council. Each program runs 15 minutes.

Covered in the series are such vital topics as "How Small Towns Can Get a Doctor," "How Small Towns Can Keep a Doctor," "Training Rural Doctors," "Working Together for Health" (health councils) and "Projects for Your Health Council." The theme that "self-help is the American way" runs throughout the programs.

National Conference on Trichinosis

The American Medical Association has joined with the U. S. Public Health Service, the U. S. Bureau of Animal Industry, the American Public Health Association and the American Veterinary Medical Association in sponsoring a National Conference on Trichinosis. The meeting is scheduled for December 12 at AMA Headquarters, Chicago.

It is hoped that the Conference will stimulate interest in the need for further public education of the dangers of trichinosis. Doctors Leonard W. Larson, Bismarck, and J. J. Moore, Chicago, were appointed AMA representatives by the Board of Trustees.

First Aid Guide Now Available

Useful tips on how to handle common first aid emergencies have been compiled in a pocket-sized manual by the AMA's Council on Industrial Health and the Bureau of Health Education. The booklet outlines adequate first aid instructions for everyday illnesses and injuries in a simple way. It is designed to guide those who have not received formal first aid training as well as to refresh the memories of the experienced. A list of suggested items for a first aid kit also is included.

Single copies are available without charge through either of these AMA departments. Quantity prices will be supplied on request by the Order Department.

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COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Ashland-Bayfield-Iron	C. A. Grand 522 W. 2nd Ashland	J. E. Kreher 522 W. 2nd St. Ashland	
Barron-Washburn-Sawyer-Burnett	R. E. Lund Cumberland	Clive J. Strang Barron	Second Tuesday 7:30 p.m.
Brown-Kewaunee-Door	J. L. Ford 3030 S. Webster Green Bay	G. M. Shinners 409 E. Walnut Green Bay	Second Thursday*
Calumet	E. P. Larme New Holstein	J. M. Guthrie Brillion	
Chippewa	T. D. Foster Cornell	B. F. Rahn Cadott	Second Tuesday
Clark	K. F. Manz Neillsville	J. W. Koch Owen	
Columbia-Marquette-Adams	R. F. Inman Montello	E. G. Nafziger Oxford	Second Tuesday 7:00 p.m.
Crawford	O. E. Satter Prairie du Chien	H. L. Shapiro Prairie du Chien	
Dane	G. H. Ewell Jackson Clinic Madison	G. C. Hank 110 E. Main Madison	Second Tuesday
Dodge	C. L. Qualls Beaver Dam	R. E. Urbanek Beaver Dam	Last Thursday*
Douglas	C. T. Droege 1507 Tower Superior	R. T. Anderson 1507 Tower Superior	First Wednesday** Badger Room of the Hotel Superior
Eau Claire-Dunn-Pepin	W. G. Cameron 131 S. Barstow Eau Claire	H. E. Sorensen 314 E. Grand Eau Claire	Last Monday
Fond du Lac	F. J. Cerny 80 Sheboygan Fond du Lac	N. O. Becker 104 S. Main Fond du Lac	Fourth Thursday*
Forest	O. S. Tenley Wabeno	D. V. Moffet Crandon	
Grant	N. G. Rasmussen Montfort	H. W. Carey Lancaster	Last Thursday, March, June, Sept. and Nov.
Green	D. D. Ruehlman Monroe	L. G. Kindschi Monroe Clinic Monroe	
Green Lake-Waushara	Roy Hong Wild Rose	R. S. Pelton Markesan	Last Thursday, every other month starting in Jan.

List of Officers and Scheduled Meetings of County Medical Societies—Continued

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Iowa	C. L. White Mineral Point	H. M. Walker Dodgeville	First Thursday following first Monday
Jefferson	E. A. Miller 133 Riverlawn Watertown	E. J. Netzow Lake Mills	Third Thursday*
Juneau	J. S. Hess Mauston	M. S. Tverberg Mauston	Second Tuesday Hess Clinic in Mauston
Kenosha	H. L. Schwartz 625 57th Kenosha	Helen A. Binnie 7609 25th Kenosha	First Thursday* Elks Club Kenosha
La Crosse	J. J. Satory 1707 Main La Crosse	D. M. Buchman 308 Newburg Bldg. La Crosse	Third Monday
Lafayette	D. J. Garland Shullsburg	N. A. McGreane Darlington	First Tuesday
Langlade	D. W. Dailey Elcho	F. H. Garbisch Antigo	Second Wednesday
Lincoln	L. J. Bayer Merrill	J. D. Millenbah Merrill	
Manitowoc	C. J. Radl Wood Block Manitowoc	W. C. Randolph 819 Hancock Manitowoc	Last Thursday
Marathon	D. M. Green Trust Bldg. Wausau	G. R. Hammes 529½ 3rd Wausau	
Marinette–Florence	J. M. Bell 1723½ Main Marinette	R. J. Rogers Oconto	Third Wednesday St. Joseph's Hospital
Milwaukee	N. J. Wegmann 2510 W. Capitol Milwaukee	W. T. Casper 2218 N. 3rd Mr. J. O. Kelley, Ex. Sec. 208 E. Wisconsin	Second Thursday
Monroe	C. E. Kozarek Tomah	J. S. Mubarak Tomah	Third Monday
Oconto	H. A. Aageson 1113 Main Oconto	G. R. Sandgren Suring	
Oneida–Vilas	G. R. Thuerer 1020 Kabel Rhinelander	Marvin Wright 1020 Kabel Rhinelander	Monthly
Outagamie	L. B. McBain 128 N. Durkee Appleton	W. A. Adrians 118 W. College Appleton	Third Thursday* Elks Club 6:30 p.m.
Pierce–St. Croix	E. F. Hill Spring Valley	P. H. Gutzler River Falls	Third Tuesday
Polk	W. A. Fischer Frederic	G. B. Noyes Centuria	Third Thursday 7 p.m.
Portage	M. G. Rice Stevens Point	H. A. Anderson Stevens Point	
Price–Taylor	J. L. Murphy Park Falls	J. J. Leahy Park Falls	Last Saturday, Feb., May, Aug., and Nov.
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Richland	J. I. Spear Richland Center	L. M. Pippin Richland Center	First Tuesday Richland Hospital
Rock	M. M. Baumgartner 508 W. Milwaukee Janesville	J. F. Pember 508 W. Milwaukee Janesville	Fourth Tuesday
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Waupaca	L. G. Patterson 122 S. Main Waupaca	R. E. Bolinske Clintonville	
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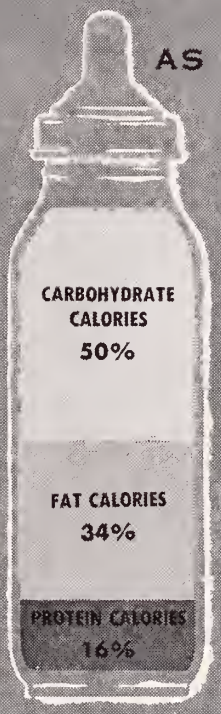

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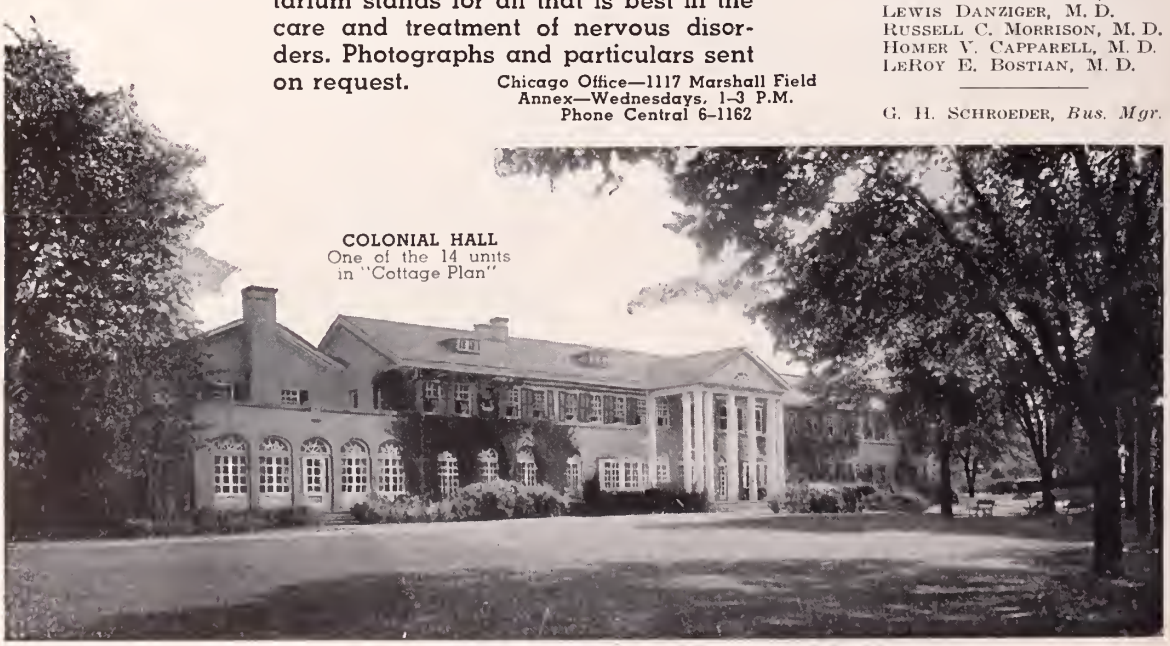

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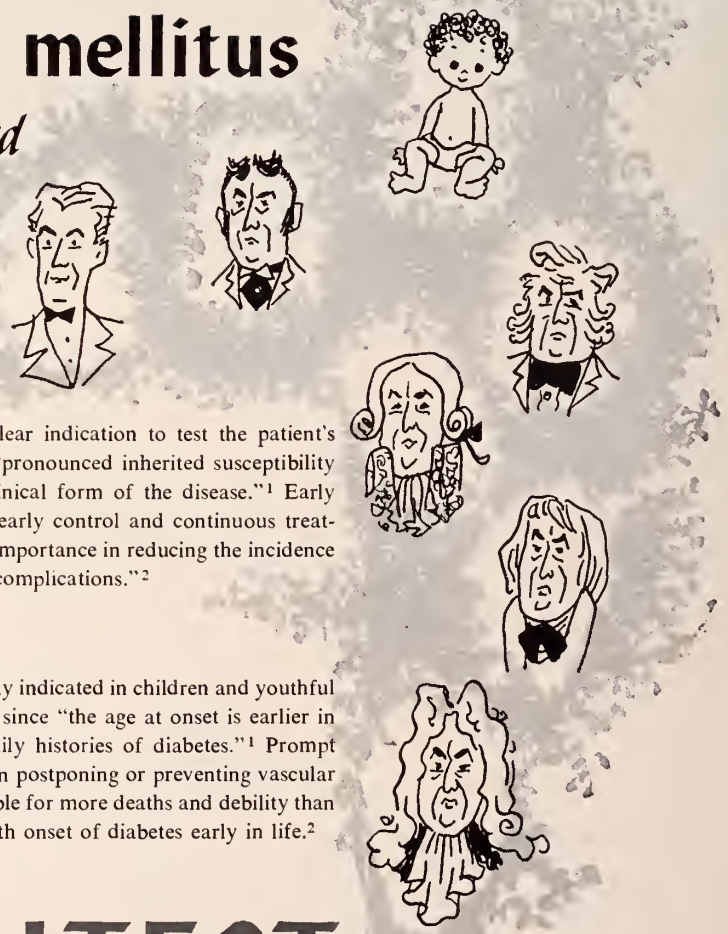

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1. Watson, E. M., and Thompson, M. W.: Am. J. Digest. Dis. *18*:326, 1951.
2. Wilson, J. L.; Root, H. F., and Marble, A.: J.A.M.A. *147*:1526 (Dec. 15) 1951.

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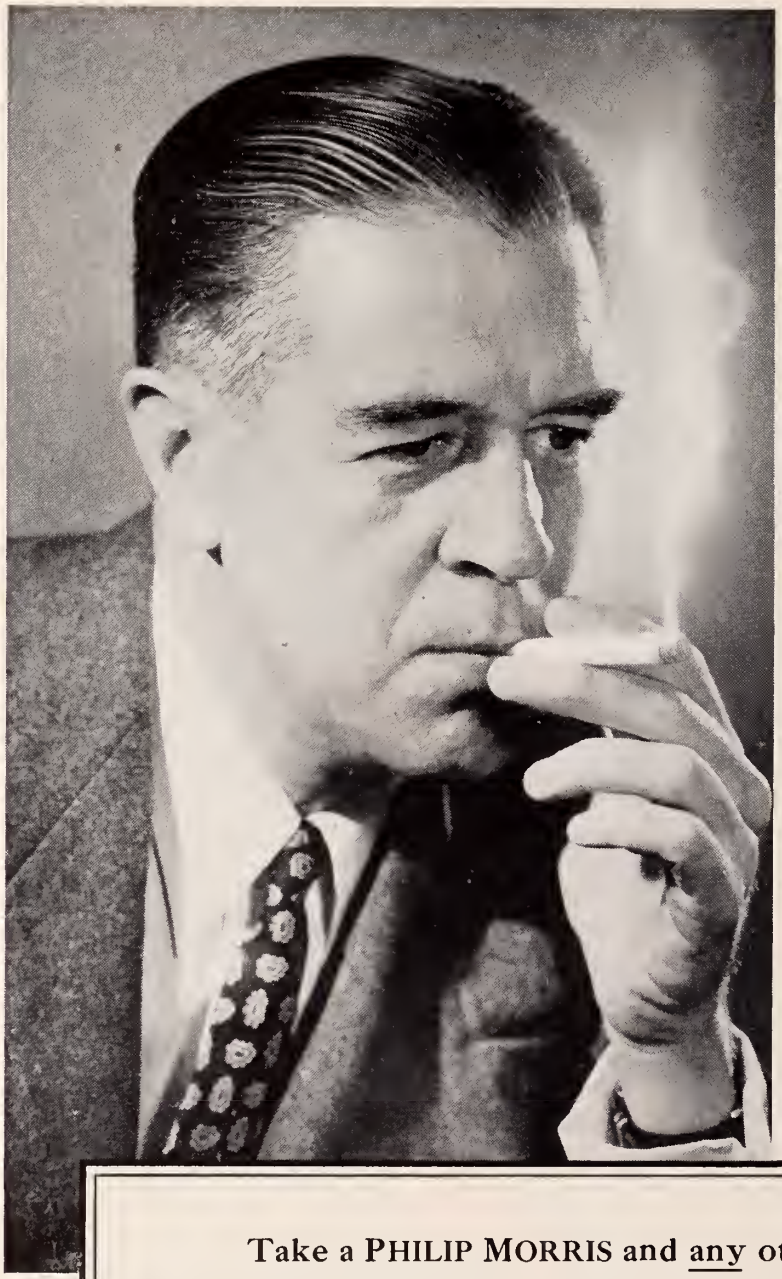

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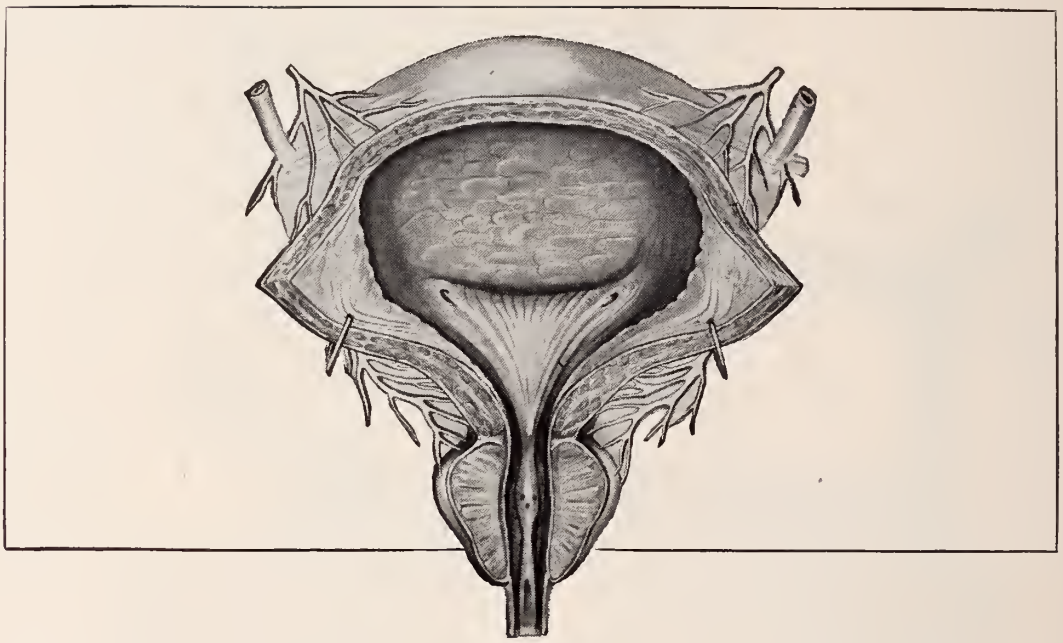

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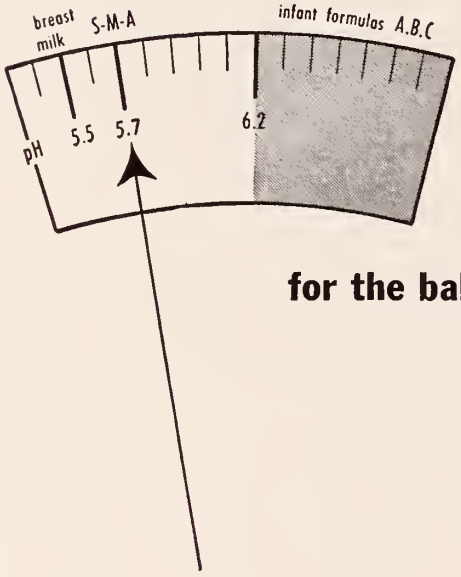

- produces a stool with a pH "practically identical" with that of the infant fed human milk. Stools of babies fed other formulas are distinctly more alkaline (6.2 to 6.7).[1]

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2 *Lower incidence of constipation.* Formation of calcium soaps is inhibited; acid produced by fermentation stimulates peristalsis.

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4 *A stool typical of the breast-fed infant*—having a "buttermilk-like", rather than putrefactive odor.

5 *Vitamins more readily available, especially vitamin* B_{12}. Growth of putrefactive organisms which reduce amounts of vitamins available[2] is inhibited.

6 *Minimal danger of perianal dermatitis and diaper rash in the new-born.*[3]

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That meat is an important component of the high protein diet[1] employed in the treatment of many pathologic states is evident from the following dietary suggestions that have been recommended by some authorities in the field of nutrition:

Protein of good quality and in adequate amounts is the most effective dietary agent for protecting the liver from damage and for promoting its repair.[2] In the long-term management of chronic liver disease, a suggested diet includes at least 4 ounces of lean lamb, veal, or beef in both the noon and evening meals.[3]

Among the nutritional needs of patients with chronic ulcerative colitis is protein.[4] For such patients a recommended diet includes 4 ounces of tender meat with luncheon and with dinner.[5a]

In diabetes mellitus, maintenance of protein reserves is important for supporting well-being and vigor, for maintaining resistance to infection, and, in conjunction with good general management, for minimizing many of the degenerative changes commonly seen in this condition.[6,7] One ounce of bacon at breakfast and 2½ ounces of cooked meat at each of the other two meals are valuable in a diabetic diet.[5b]

A program of treatment[8] found useful in atherosclerosis of the coronary vessels includes an adequate diet low in fat (20-25 Gm. daily) and normal or moderately high in protein (60-100 Gm. daily), in conjunction with lipotropic agents. A sample menu of this diet lists 2 ounces of lean meat at both the noon and evening meals.

Underweight or average weight patients with persistent low blood sugar levels are benefited by a high protein diet providing meat two or three times a day.[9] In overweight patients of this type, lean meat is served at luncheon and at dinner.

During convalescence from infectious disease, the importance of "high protein-high calorie" diets including generous servings of meat deserves emphasis.[10] For this purpose, a suggested typical daily menu schedule which results in weight gain, improved vigor, and a restored sense of well-being furnishes ½ ounce of bacon at breakfast and 3 ounces of meat at each of the other meals. Supplementary feedings may include additional amounts of meat.

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The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

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*Adams, C. H., and Cecil, R. L.: Ann. Int. Med. 33:163, 1950.

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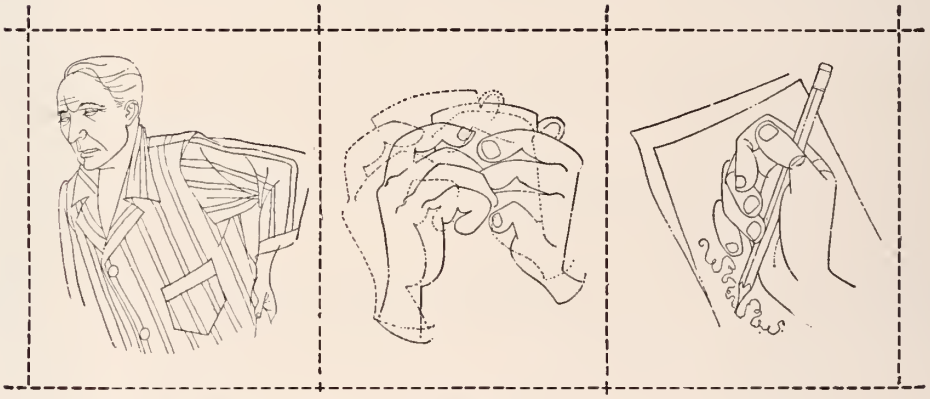

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The first dose prescribed should be at the lower end of the recommended dosage range *(an occasional patient may complain of side effects when* large *doses are given at the* start *of Tolserol therapy).* Subsequent doses may be adjusted to the needs of the individual patient. Whenever possible, Tolserol should be given after meals. When Tolserol is given between meals, it is desirable that the patient first drink 1/3 glass of milk or fruit juice.

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H.P.S. Sixty provides 3.6 calories per gram, 102 calories per ounce.

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« « « EDITORIALS » » »

The 1952 State Medical Convention

Another State Medical Convention has gone down in history and they seem, to this writer, to be getting bigger and better each year. The Council on Scientific Work is again to be commended for an excellent scientific program, and our assistant secretary, Roy Ragatz, together with the rest of the staff of the State Medical Society handled the multitudinous details of putting on the convention in their usual workmanlike manner.

The program retained small group teaching programs, the clinical conferences, the ever popular round table luncheons, and the general scientific sessions. One departure was that special symposia were substituted for the various specialty programs and were interspersed throughout the general scientific session, with the sole exception of the section on ophthalmology and otolaryngology, which had its own program on Wednesday at the Hotel Schroeder.

This doing away with the separate section programs was a trial balloon of the Council on Scientific Work and, if the majority of the membership prefer it this way, it will undoubtedly be continued. There are several objections, however, that this writer can see with doing away with the specialty sections. The number one objection is that the speakers are cognizant of the fact they are presenting their subjects to all branches of the medical profession and become so generalized in their presentation and so elementary on some occasions that the presentation becomes a complete waste of time for many of the physicians listening to it. Another objection is that the stimulation of listening to some new, original, and maybe experimental approach to a problem is lost when the essayist stays away from controversial issues completely and presents only the basic fundamental concepts agreed to by everyone. In illustration, one of the speakers, who is an eminent authority in his subject, presented his material so basically and in such generalized terms that a third year medical student could have absorbed every word completely. This, to my mind, was unfortunate because there is no question about the speaker's ability to present the subject in any manner that he felt was wanted.

Admittedly, the programs can be ultra-scientific to the point where only a few men would be interested or, on the other hand, the pendulum can swing so far the other way that, in striving to arouse everyone's interest, they become too basic. It would seem that a happy medium is to be striven for and that the only way that this could be accomplished

would be to revive the sectional meetings so that the membership can pick and choose the various presentations in which they are especially interested.

This editorial is written only with the idea of being thought provoking and with the hope that it will stimulate discussion. If anyone feels in the mood to give his own thoughts on anything he thinks will improve our State Medical Society Convention, I am sure the Council on Scientific Work would be very interested in hearing them and, if they are of enough general interest, we can publish them in the editorial section.

The Last Frontier of Surgery

Practically every organ in the body except the heart has been successfully attacked by the surgeon in an effort to repair pathologic defects, and even this organ is finally yielding to surgical approaches. Robert E. Gross, M. D., *et al.*, in the September 25, 1952 issue of *The New England Journal of Medicine*, presents an article on the surgical closure of defects of the interauricular septum by use of an atrial well which seems to be epoch making in its presentation.

On the basis of extensive laboratory investigations, a method has been developed whereby it is possible to attach an open rubber bag or "well" to an auricular wall so that the auricle can be opened into the bottom of this attached sac. Blood rises up into such a well to a height equal to the intra-auricular pressure. Through the pool of blood, kept fluid by heparin, it is possible to enter the interior of the auricle, to locate accurately any septal defect, and to close it in a careful manner. A large septal opening can be covered with an onlay sheet of plastic material, held in place by sutures. A small opening can be repaired by direct stitching and approximation of the septal margins.

Doctor Gross and his group present two successful cases in which this type of repair was employed. In one case, the septal opening was found to be 2 cm. wide and 3 cm. long. A piece of nylon 0.8 mm. thick, 2.5 cm. wide and 3.5 cm. long was put in place to cover the septal defect. This patient was discharged from the hospital on the thirteenth day, and two months after the operation the cardiac murmur had disappeared and the patient was in excellent condition.

In the other successful case, two septal openings were found. A centrally located one was 1.5 cm. long and 1 cm. wide. It was closed with interrupted sutures of silk. The second defect was larger and was situated posteriorly and inferiorly; it was 3.5 cm. long and a little more than 1 cm. wide. A series of mattress stitches were placed and this defect closed without the necessity of a graft. This patient made a rapid recovery and was discharged from the hospital in twelve days and was in excellent condition two months later; the precordial murmur had disappeared.

Gross, Robert E., et al.: Surgical closure of defects of the interauricular septum by use of an atrial well, New England J. Med. 247:455–460 (Sept. 25) 1952.

"Today's Health"

Just as politicians have campaign managers and department stores employ an advertising staff, the medical profession can depend upon TODAY'S HEALTH for much of its public relations work.

This informative periodical, in its twenty-ninth year, is published by your American Medical Association and edited by a fellow physician, W. W. Bauer, M. D., in the interest of better health for the American people.

Most important is that TODAY'S HEALTH encourages understanding between the physician and the patient. It answers the patient's questions from a scientific point of view, but in simple, straight forward, "down to earth" style. Each article emphasizes the value of relying upon trained, qualified medical men—You, Doctors.

TODAY'S HEALTH is indeed a useful tool for the busy doctor, since it aims to educate the general public in modern medical methods, exposes quacks, faddists, and cultists. Patients who read this magazine will better understand what you, and the medical profession as a whole, are trying to do for them.

TODAY'S HEALTH belongs wherever people gather, in doctor's reception rooms, school libraries, club reading rooms, and in the home.

This magazine deserves your enthusiastic and active support for what it is trying to accomplish for the medical profession and the public.—MRS. R. T. SCHMIDT, *Chairman*, TODAY'S HEALTH *Subscription Committee of the Woman's Auxiliary to the State Medical Society of Wisconsin.*

Comments from the Wisconsin Press

"Recommend Health Insurance"

"The talk you once heard about the need for socialized medicine has pretty well died out—even among the more liberal Democratic circles.

"The reason is pretty obvious. Voluntarily contracted, self-paid, prepaid health care plans have been a tremendous success.

"The extent to which they have been accepted was recently pointed out by E. M. Dessloch, M. D., Prairie du Chien, who is chairman of the State Medical Society's commission on prepaid plans. He wrote: 'Today, more than half the people of Wisconsin have voluntarily provided themselves with some measure of insurance protection against the costs of medical, surgical, and hospital care. Across the nation, more than 85 million persons have hospital expense insurance, 65 million hold surgical care protection and nearly 28 million have medical expense coverage.'

"This newspaper, without reservation, strongly recommends that its readers investigate several of the health insurance plans—and then subscribe to whatever one seems to be the best to them. Insurance agents in this area will be only too glad to give free information.

"A word of warning, however. Steer clear of the mail order health insurance plans. They are usually hard to collect from when you do have a valid claim for insurance aid—and some are just plain illegal.

"Buy health insurance through local, reputable insurance men."—EAGLE RIVER NEWS-REVIEW, Oct. 2, 1952.

* * *

"State Medic Program"

"Mention of the Wisconsin program in connection with an editorial on the placing of physicians in rural areas of Texas brought this appropriate question: 'Just what is Wisconsin doing?'

"Training of physicians is increasing at a rapid rate. New medical schools are opening and 100 million dollars has been earmarked to remodel and expand other schools. Wisconsin medical schools have the largest freshmen classes in history and all indications point to an increase of 30 per cent in the production of physicians between 1950 and 1960.

"The State Medical Society has a student loan fund to help needy and deserving medical students go through medical school. The State Medical Society has a full time placement bureau to help communities find a physician, and to help doctors find a good location.

"The State Medical Society also helps doctors keep up on medical advances by sponsoring scientific clinics throughout the state, which is an important factor to the physician located a long distance from medical schools and large hospitals.

"The society aggressively advocates the establishment of full time professionally manned public health departments on a county or multiple-county basis. In another effort to solve the problem of medical service the society has proposed legislation by which physicians are appointed to serve 'necessitous' areas as public health officers and practicing physicians during the first years required to establish them in private practice.

"Actually the State Medical Society is doing a host of things to keep Wisconsin in the forefront as a healthy state."—MARINETTE EAGLE-STAR, Oct. 6, 1952.

* * *

"Medical Care Tax Deductions"

"Many people in government feel that the sick should receive benefits under social security. They point to the fact that even a modern siege of illness puts burdens on the ordinary family which it can shoulder only with great difficulty. They feel that Blue Cross and other insurance plans are but a partial answer to the need.

"Few people, however, seem concerned about what the income tax does to people with serious, or even moderate, illness.

"The federal income tax law permits a taxpayer to deduct from his taxable income any medical expenses in excess of 5% of his adjusted gross income, with a top limit of $1,250 per person. (The 5% feature does not apply to persons over 65.) Our state income tax law permits deductions of any medical costs above $50, with a maximum of $500 per taxpayer.

"A young man with an income of $5000 a year and catastrophic medical bills of $1000 can thus deduct only $750 from income for federal tax purposes and only $500 for the state tax.

"Would it not be sounder public policy to permit the deduction of *all* medical costs under a revised definition of what may be included? Surely if there is any social argument for government to *assume* the cost of medical care under social security, there is even better argument for *foregoing* taxes on money the taxpayer himself pays for such outlays."—MILWAUKEE JOURNAL, Oct. 16, 1952.

Message to the House of Delegates*

By J. C. GRIFFITH, M. D.
Milwaukee

IT IS a privilege and a pleasure, I assure you, to be your incoming president. After spending a year as your president-elect and studying the many ramifications of the State Medical Society, and the many problems that face it, it is with a certain amount of apprehension that I come up here this afternoon. I hope that I may count upon your advice and your help, always. I hope that I may be as diligent, as considerate, and just half as sincere as the man who preceded me. It is a big task. The problems of medicine are many and complex. You will discuss and deliberate on many of them here at this meeting. I would like to go into just one phase of these problems with you this afternoon and that is the relationship between government and medicine.

For the past decade and especially at the time of the last national elections, politicians were training their sights on more and better medical care at less cost to the patient. All of these aims would, if realized, contribute greatly to the health, welfare, and peace of mind of the population. The only danger inherent in accomplishing them has been that in our eagerness for the easy way we might choose the wrong way.

It has been said that our present system is grossly inadequate—that there is a shortage of hospitals, physicians, and community health protection, as well as poor distribution of the resources we have. Much has been said and volumes have been written on socialized medicine. I believe that nearly all of the doctors, and at present most of the public, are opposed to it. Another solution offered was presumably neither compulsory nor socialized medicine. It was instead government health insurance, which would be compulsory only to the extent that all persons in the categories determined by Congress would pay a certain percentage of their income in exchange for medical service benefits. Doctors would be under no compulsion to join the plan. This would supposedly preserve the elements of medical practice which we have long treasured and still would provide adequate care to everyone in the country, thereby reducing the death rate and solving all the problems of distribution of doctors and medical facilities. It was a rosy picture, but we questioned seriously whether we alone of all nations which have attempted this sort of program would be able to make it successful. We saw in it dangers to the future health of the public and dangers to the advancement of the standards of medical practice, and we organized a fight against it. We seem to have won, at least for the present.

It is an election year, and this election is only about a month away. If the two party platforms give reason for hope that the people's health will not be used as a football on the political gridiron, they constitute a timely tribute to the forces of aroused public opinion.

In the health plank of the Republican Party platform you may see this statement: We are opposed to federal compulsory health insurance with its crushing cost, wasteful inefficiency, bureaucratic dead weight, and debased standards of medical care.

You are all aware of General Eisenhower's stand in this matter. He leaves no doubts about that. Senator Nixon has been just as forceful in his stand against government medicine. He praised the program of subsidizing medical schools on a voluntary rather than on a government basis. He said, "I would suggest, also, that additional, voluntary action is needed in dealing with the problem of encouraging, wherever possible, voluntary health insurance programs. It seems to me that the objective toward which we should work in the United States is a system where eventually anybody who wants health insurance can get it, where those who should have health insurance are encouraged to get it, but where no one in the United States is compelled to take out such insurance against his will."

Governor Stevenson states, "I am against the socialization of the practice of medicine as much as I am against the socialization of my own profession, law. If the insurance principle could be brought to bear in these catastrophic illnesses, it would largely eliminate the specter of terror from the average home. I am sure that the common objective can be largely realized without the destruction of professional independence. Basically, the problem is how to lift people over the cost of major illnesses. I do not know whether voluntary plans can do the job. I think that the new Commission on Medical Needs may well add some lights and remove some heat enabling us to find some solution to this perplexing problem."

Senator Sparkman has said, "I am in favor of adequate medical protection for the people of this country. However, I have not favored what is generally known as socialized medicine. I am opposed to any plan which I thought would in effect socialize medicine and to any medical program which would destroy the relationship of doctor and patient."

It is true that in 1949 when roll was called in the Senate on President Truman's reorganization plan, which would have created the Department of Welfare, Mr. Sparkman stood with medicine in opposition to giving Cabinet status to Federal Security Administrator Oscar Ewing.

*Presented before the House of Delegates, One Hundred and Eleventh Anniversary Meeting of the State Medical Society of Wisconsin, Milwaukee, 1952.

The health plank of the Democratic Party states that they will continue to work for better health for every American. They pledge continued wholehearted support to the campaign that modern medicine is waging against mental illness, cancer, heart disease, and other diseases. They favored research from private and public sources, advocated federal aid for medical education, pledged continued support for hospital construction, and said this of the cost of medical care: We advocate a resolute attack on the heavy financial hazard of serious illness. We recognize that the cost of modern medical care has grown to be prohibitive to many millions of people. We commend President Truman for establishing the nonpartisan Commission on the Health Needs of the Nation.

This Commission met about a month ago in Minneapolis and in one day's time went into the health needs of six states and eleven million people. On a notice which included eight working days your State Medical Society was given 10 minutes to present the health needs of Wisconsin. The chairman of your Council appeared and in 10 minutes told them a great deal. He also wired both General Eisenhower and Governor Stevenson about the limitations of the hearing and asked them their intentions as to the future of the Commission.

We are still convinced that government health insurance is not the answer to the needs of the people. We are confronted with all these statements that a need does exist. This constitutes a challenge to all of us. I go along with the voluntary insurance principle. In the nation generally and in Wisconsin in particular, it is operating quite well. Under private companies and the Wisconsin Plan, about 1,200,000 people are insured for surgical and medical care, and under the Blue Shield plans, the Wisconsin Physicians Service and Milwaukee Surgical Care, approximately 650,000 people are insured. This is almost two million people.

This sounds very good but it is not enough. It is slightly more than one-half of the people of Wisconsin. Many of those who are insured do not need it, and certainly many of those who need it, are not insured. Benefits need to be broadened as rapidly as it is possible.

Wisconsin Physicians Service during the last year has increased its benefits and broadened its coverage. The whole program has grown rapidly, but it is not growing as fast as it did.

The saturation point certainly has not been reached. Service needs to be extended. Catastrophic insurance has to be considered, and there are other possibilities such as a paid-up health insurance for those who have purchased it or for those who have belonged for a long time and have come to the end of their employment. Health insurance needs to be brought to other than metropolitan areas. It needs to be spread to the counties with less population, to the village, and to the farm. It needs promotion; it needs more vigorous sales.

Another relationship that the government has with the medical profession in general comes under Selective Service. Our country is not at war, but our government finds need for a sizeable armed force for defense, for preparedness, and in the pursuit of the unofficial war in which we are engaged. This requires medical officers, doctors. Many of those now serving have served their allotted time and need to be replaced. Where are they coming from? All of you up to 51 years of age, along with members of the dental and other professions, have been registered under a special Selective Service Act that makes you available for military service. The medical profession has a responsibility to our government in trouble just as we have to our patient in trouble.

We recognize this responsibility, but at the same time it should be pointed out that the health professions have been designated by law as having an unusual and peculiar obligation for military service —an obligation above and beyond that of the average civilian. This seemingly discriminatory situation may be tempered by the practical necessity of meeting greatly increased military needs from a relatively stable pool of civilian physicians. If the doctor draft is continued, it behooves the State Medical Society and the American Medical Association to do everything possible to assure its continuation on the most equitable and realistic basis. Furthermore every effort should be exerted upon the Armed Forces to utilize physicians in the most efficient and worthwhile manner.

Meanwhile, the law exists, and under it physicians are divided into four priorities. Priority I includes those who have had their training at government expense and less than 90 days' service thereafter. Priority II are those who had their training at government expense but more than 90 days and less than 21 months of service thereafter. These two priorities are now just about exhausted. Priority III are those without training at government expense or deferment to continue studies leading to a medical degree and who had no service in the Armed Forces subsequent to September 16, 1940. Priority IV includes those with a service record since 1940.

Wisconsin Selective Service local boards have received instructions to start the classification of all Priority III physicians, and they have. About 650 physicians and 400 dentists received 1-A notices from their local boards. Local boards were required to place them in a 1-A classification for the purpose of physical examination. The Advisory Committee to Selective Service is investigating the essentiality of registrants and will make a recommendation of available for service or essential to the local board. Being classified 1-A in Priority III does not mean that the physician at this time will be drafted. Physical examination and determination of essentiality are being made now as a part of advanced planning. There will be many graduates from medical schools during the next year; but of these, many

graduates, probably as many as one-third, will not pass the physical examination; and it will be necessary for Selective Service to call some older Priority III physicians for some of the medical personnel. I understand that it is the plan to select the younger men first. Determination of essentiality or availability is a complex procedure. Final determination is the duty of the local board. There exist in Wisconsin, however, two advisory committees which are charged with the responsibility of assisting in this determination. First, there is the Advisory Committee to Selective Service and Reserve Branches made up of a physician, a dentist, a veterinarian, a nurse, and the state health officer. These have presidential appointments; Doctor Weston of Madison is the physician representative. Your State Medical Society has a committee to assist them. Doctor Weston is chairman of this committee. He and his committee are working hard. They are receiving letters, telegrams, and telephone calls. The intern is still in medical school and is not available until he has completed his internship. Some third and fourth year residents are essential, especially if the services in their hospitals are for a large part dependent on them. Certain members of medical school faculties are essential. Some undoubtedly could be spared. Some practicing physicians in communities where the health of a goodly sized segment of the population depends on them will probably be declared essential. Some of these were declared essential during World War II. Since that time other physicians have moved into the area, and these men may be declared available now because they fall into Priority III.

It is a very difficult task. Doctor Weston and his committee are working conscientiously, and I am sure you can depend upon them to do a self-sacrificingly good job; help them all you can.

I would like to take up one other phase of the relationship of the doctor and the government. Recent years have seen the development of health bureaucracy in government. There are 40 different federal agencies rendering some federal medical service. Our state does not have that many, but many of the programs are administered by the state; and in order for the state programs to qualify for federal money, certain criteria are set up. If these are not fulfilled, either the program may be operated from the federal level, or no money will be available to the state. You probably do not realize the many ramifications of the program and the amount of money involved. Here are some of them:

1. *The Department of Veteran's Affairs*—In the past fiscal year this department has made direct grants in the amount of $51,300; and since the program began in 1943, it has granted $896,700. It has made loans of $14,000,000. Most of these were for homes or to help the veteran setting up a business; but, undoubtedly, some of it was for the veteran to meet a large or unexpected medical and hospital expense.

2. *Public Health*—The appropriations for the State Board of Health for 1952 and 1953 are $1,416,264. Of this, $752,335 is to come from the federal government and $663,929 from the state. This includes federal aid for maternal and child health, general health, cancer, mental health, heart disease, venereal disease, and tuberculosis; and state appropriations for general health, laboratories, industrial camps, nursing homes, and water pollution. In addition, the State Board of Health handles $2,000,000 in funds for sanitoria and county aid to public health nurses. There is $1,500,000 coming into Wisconsin for federal aid for hospital construction; $2,000,000 is being spent throughout the state in local public health activities. Total this up. There is approximately $7,000,000 being spent in the general field of public health.

3. *Public Welfare*—The two principal divisions of this, as far as we are concerned, are the Division of Public Assistance and the Division of Mental Hygiene. Almost $8,000,000 is spent annually for health care for persons receiving public assistance aids.

4. *Rehabilitation Division of the State Board of Vocational and Adult Education*—This division spent $641,895 during 1949 and 1950. Of this, $415,000 was directly related to medical service.

5. *Workmen's Compensation Division of the Industrial Commission*—Our open panel program is very closely tied in with this commission. From June 30, 1951 to June 30, 1952, $10,918,000 in benefits have been paid out. At least $2,782,000 of this was for medical and hospital benefits, not including those for less than three days' illness or accident care.

6. *Department of Public Instruction*—In 1950 and 1951 it spent $25,000 for the administration of crippled children's programs, $1,158,000 in public instruction aids from the general fund for physically handicapped children, day school for the blind, deaf, and speech defective children, exceptional children, mentally handicapped, and otherwise. The schools for blind and deaf cost the state $460,000 annually.

7. *Federal Security Administration, Old Age and Survivor's Insurance*—The total payments for the year ending June 30, 1951 were $37,317,000. Much of this was used to pay medical and health costs.

8. *The Wisconsin General Hospital*—During the fiscal year ending in 1951 the hospital and its orthopedic branches spent $1,429,000 for the care of patients. Appropriations for research from the state general funds for the fiscal year ending 1952 were as follows: Cancer—$37,000; Rheumatism and Arthritis —$30,000; Brucellosis—$41,000. There are undoubtedly other state and federal funds coming into the university for research.

So you see, this whole project is tremendous in its size and scope. I believe that a more realistic program within the medical profession is required in order to keep abreast of current programs, in advance of current trends, and in the position of greatest assistance in the public health picture.

Industrial Dermatoses

By HARRY R. FOERSTER, M. D.
Milwaukee

THE FIRST OF TWO PARTS

A RELATIONSHIP between occupational exposures and skin eruptions was recorded in the sixteenth century. It was probably recognized in earlier civilizations but interest in the subject remained largely academic for hundreds of years and was recorded at random chiefly by English, French, and German dermatologists, in that sequence, as industrialization and socialization progressed in their countries. Charles White appears to have been the first American to direct attention to the importance of occupational dermatoses when he commented on dermatitis venenata "in the arts" in 1896. However knowledge and interest in the subject in this country lagged for another quarter century.

Skin diseases resulting from occupational activities may therefore be considered a product and a responsibility mainly of our present generation. Knowledge concerning them is also chiefly an achievement of this era.

The development of industry in the United States, particularly where concerned directly or indirectly with chemicals and their products, has been characterized by an increase in the variety, scope and incidence of occupational dermatoses. A progressive development of compensation laws and other legal provisions for the disabled workman, keeping pace with an increase in industrial diseases and advances in their management, has created a modified form of socialized medicine concerned with occupational disease.

A personal interest in the welfare and recovery of the workman patient by an informed and sympathetic physician, with intelligent and effective cooperation between physicians, insurance carriers, and employers in the management of this group of cases, should effectively meet the challenge of government controlled medical practice. The American Medical Association, through its Council on Industrial Health, has set the pace in promoting the welfare of the worker in industry. State and local groups will follow this leadership.

At present attention has again been focused on the importance of a thorough understanding of the industrial dermatoses because of the acceleration of industry in the national defense program. We are faced with the same obligations that confronted us in the previous war emergency, namely keeping workers in defense industries off the disability lists or expediting their return to work at a time of actual or threatened labor shortages. This applies particularly to skilled labor.

At the present time, in a United States population of 151 million, 60 million or about 40 per cent comprise the labor force. The heavy industries employ 25 million of whom over 15 million are in manufacturing and 21 million in service industries. Unskilled workers comprise 20 per cent, semi-skilled 23 per cent and skilled workers and foremen 14 per cent. These are the activities and groups with which we are most concerned in this discussion. Only the unskilled workers can be readily replaced when disabled by disease or injury and then only when there is a labor surplus.

With the present prospect of 4 million in our military service making inroads on the available labor field, and with an increase in the demands for workers in war service accelerated industries probably exceeding 3 million, it is inevitable that recruits for labor must be obtained from younger and older male age groups than those customarily employed, and from women. The incidence of dermatoses is always higher in these categories. The incidence of dermatoses is also always higher in new industries and in new activities, until the dermatologic hazards have been recognized and corrected and workers are adjusted to the exposures.

It has been estimated that at any normal time a factory inspection is made in the United States approximately 1 per cent of workers can be found with occupational dermatoses. These comprise two-thirds of the occupational diseases for which compensation is paid. The majority of occupational dermatoses are not disabling and are therefore not recorded as compensation cases.

It should be clear that these circumstances present problems worthy of our consideration. We must be prepared to recognize industrial dermatoses promptly, to treat them correctly and expeditiously, and to aid in their prevention.

In dermatologic practices in cities the incidence of occupationally acquired dermatoses varies from 5 to 20 per cent according to the type of practice. Possibly a third of the dermatoses, exclusive of injuries, seen in industrial workers, are not caused by their jobs. The proper management of industrial dermatoses in any practice must therefore be based on a fundamental knowledge of general dermatology. One cannot practice industrial dermatology without that background. Dermatologic consultation will often expedite recovery when the physician is limited in dermatologic experience. The dermatologist, to cooperate intelligently, must familiarize himself with industrial problems.

Most effective results will follow an organized cooperative program in which the general practitioners, industrial physicians, and dermatologists cooperate with health officers, employers, insurance

carriers, industrial engineers, and governmental agencies.

At this time I will discuss some of the more important dermatologic problems that confront physicians in industry and in general practice in industrial communities. These are concerned with dermatitis venenata or contact dermatitis, infectious eczematoid dermatitis, and bacterial and fungus infections.

Dermatitis Venenata

The most prevalent skin conditions in industry are undoubtedly minor injuries and minor infections associated with injuries, but the majority of severe and disabling dermatoses are instances of dermatitis venenata or contact dermatitis. While dermatitis venenata is usually correctly diagnosed the exact exciting agent, whether occupational or non-occupational, cannot always be determined without careful study. Often dermatitis venenata is confused with dermatitis resulting from infections, particularly of the mycotic or fungous type and with eczemas of allergic and endogenous origin. Complications are frequent and difficult to correct, and disabilities and recovery may be protracted. Early recognition and correct early treatment are therefore of utmost importance.

Dermatitis venenata is an inflammation of the skin resulting from contact with an irritant agent, usually of chemical but sometimes of plant or animal origin. The contact produces an inflammation first in the epidermal cells and then in the dermis, with associated vasodilation and edema. The effect of the latter on sensory nerve endings produces pruritus of variable severity which may be the patient's first intimation of trouble. The eruption may be a simple erythema, a vesicular or exudative inflammation, or a chronic thickening or lichenification of the skin, depending upon the intensity of the irritation and the frequency and duration of the exposure. The inflammation is most often diffuse. It may be patchy and circumscribed. The character and configuration of the earliest manifestations and their localization may be the key to the diagnosis.

Difficulty in recognition may result following alteration through manual irritation, neglect, or secondary infection. Aggravation of dermatitis may result for similar reasons or as a consequence of injudicious treatment or intolerance of medication through previous sensitization. Traumatic, physical, and infectious dermatitis are to be differentiated. Dermatitis venenata frequently results from cleansing agents used at work or from exposures occurring at home or at an avocation, instead of from a suspected material with which contact has been made in employment. Minor mechanical injuries of the skin from abrasive particles in materials used, such as metal particles in grinding oils and solutions, frequently serve as portals of entry for either chemical irritants or infection. Softening of the protective keratin covering of the skin or excessive removal of protective sebum by strong soaps, alkalies, and solvents, or sweating sufficient to macerate the epidermis or to produce solution of a solid chemical, may result in dermatitis from contacts that would otherwise not be harmful. The incidence of occupational dermatoses always increases very much during hot weather.

In certain individuals and under certain circumstances, any chemical may provoke dermatitis. The eruption is usually first localized approximately to the site of most immediate and most frequent contact with the offending agent. It may however be generalized at the onset when caused by an agent that is in the form of a vapor, dust or readily diffusible liquid. Whatever its cause, it frequently becomes widespread and even generalized if not promptly recognized and the exciting cause removed.

The chemicals responsible for dermatitis venenata are grouped into *primary irritants* and *sensitizers*. It is necessary to differentiate them to understand the mechanism involved in the development of the dermatitis. Primary irritants are responsible for approximately 80 per cent of cases of contact dermatitis in industry and for about 50 per cent of those arising in household activities.

A *primary irritant* is a chemical that may cause dermatitis in any individual under certain circumstances, frequently directly after the first contact. Such dermatitis is usually the result of an accidental or prolonged contact with an agent against which protective measures are routinely employed. It may follow accidental concentration of a chemical not usually irritating in its customary form or strength. It may occur after contact with a new or an unfamiliar compound, the irritant properties of which had not been previously recognized. Occurrences of the latter type are a common experience in this present era of chemistry in industry.

The American Medical Association Council on Industrial Health published the following legal definitions prepared by the Committee on Industrial Dermatoses.

"An occupational dermatosis is a pathological condition of the skin for which occupational exposure can be shown to be a major causal or a major contributory factor."

"When a substance in a given concentration, in a given vehicle and after a given manner and length of exposure produces clinically manifested irritation in the skin of the majority of persons not previously sensitized to that substance, then that substance is a primary irritant under the specified conditions." "The irritation may be redness, papulation, vesiculation, ulceration or other sign of damage at the site to which the irritant has been applied."

A simplified definition for practical purposes is: "A primary cutaneous irritant is an agent which will cause dermatitis by direct action on the normal skin at the site of contact if it is permitted to act in sufficient intensity or quantity for a sufficient length of time."

Most workers avoid dermatitis from primary irritants because of a knowledge of their potentialities, by use of protective devices, by avoiding unnecessary or prolonged contacts when exposures are unavoidable, and by cleanliness as regards personal hygiene and work clothes. The incidence of primary irritant dermatitis may be high in new employees and in new processes because of lack of familiarity with the hazards and how to minimize them.

The prevention of dermatitis from primary irritants is clearly a field for education of employees by first-aid personnel under supervision of the industrial physician or nurse. It is an important field for the industrial engineer and hygienist in devising and promoting procedures for eliminating or minimizing harmful exposures and contacts and by facilitating adequate sanitation and factory hygiene.

Numerous published lists of primary irritants are available. The chemicals usually recorded as most frequent irritants are strong alkalies, strong acids, metallic salts, solvents, petroleum, organic acids and anhydrides, chloronaphthalenes, tars, and formaldehyde compounds.

Sensitizers or Allergens are chemicals that are non-injurious to most skins under normal conditions of exposure. They are responsible, however, for approximately half the cases of dermatitis venenata occurring in the home environment and for about 20 per cent of those in industry.

A *sensitizing agent* has been defined as "a chemical that increases the tissue capacity to react to subsequent exposures." Sensitizers do not cause demonstrable cutaneous changes on initial or primary contact but may cause specific changes in the skin after an incubation period of several days to months and even longer. Hypersensitivity means having a greater than normal capacity to react. The recognition of the cause of a sensitization dermatitis is more difficult to determine than that resulting from a primary irritant. The dermatitis may therefore become more severe and more protracted.

In the *allergenic group*, sensitization results from repeated chemical action on localized areas of epidermis with the possibility of a local development of sensitizing agents or allergens. This localized epidermal allergy is frequently followed by a generalized cutaneous sensitization with lesions appearing beyond the areas of contact exposure. The manner of extension of sensitization is centrifugal by way of the cutaneous lymphatics or systemic by way of both blood and lymph streams.

Patch testing is resorted to in the search for a sensitizing agent as the cause of contact dermatitis. When the allergy is localized to the area of contact, such tests are likely to be negative when applied to normal skin areas, unless the substance is a primary irritant.

A primary irritant in such dilution that it does not act as an irritant on the majority of skin with which contact has been made may become a sensitizer. Patch tests with primary irritants should be made only in such dilutions.

Among important sensitizing agents are soaps and other cleansers, organic and inorganic oils, natural and synthetic resins, waxes and plasticizers, dyes and dye intermediates, metallic salts, rubber accelerators and anti-oxidants, photo developers, photo sensitizers, plant products, explosives, drugs, and medicaments.

Schwartz is of the opinion that most workers who are not disabled by a sensitization dermatitis and who continue at work will develop a tolerance or hyposensitivity in from three to six weeks. This is referred to as "hardening" and may result from a thickening of the corneous layer of the epidermis or be the consequence of an immunological reaction. It is contrary to what one would expect and apparently occurs chiefly in instances of dermatitis of moderate severity insufficient to cause disability and often not seen by the physician.

Schwartz has stated also that in less than 10 per cent of workers who acquire sensitization dermatitis a tolerance fails to develop and they are required to change their jobs. He believes that there is a high degree of specificity in industrial sensitization dermatitis and also a frequent immunization.

It has been our practice to permit workers with moderate dermatitis to continue at work but to urge a temporary change of jobs until recovery or the use of protective creams and devices. When a worker has a severe dermatitis or an early recurrence of dermatitis, we have usually urged a permanent change of employment in a belief that repeated recurrences will result in an inevitable intensification of the dermatitis and prolonged disability. It has been our observation that older workers, usually those past 50, are the ones in whom severe recurrences, generalization of dermatitis, multiple sensitivities, and protracted disabilities most frequently develop.

Peck, Sulzberger, and others are of the opinion that polyvalent sensitivities are frequent and they have called attention to the possibilities of "cross-sensitization" predisposing to the development of contact dermatitis, persistence of dermatitis and recurrences following exposures to chemically or immunologically related substances. Peck has warned that the extensive and sometimes routine use of antibiotics, sulfonamides, and antihistamines for the prevention of respiratory infections in industrial employment may result in many such incidents. Conservatism should be practiced, particularly in prescribing sulfonamides and in administering penicillin. We have seen many cases of severe, very protracted, and disabling urticaria following penicillin injections, the need for which was not always clear. Evidence of penicillin sensitivity may not show itself until two or three weeks following the last injection and may continue for weeks and months.

In addition to medicaments for local application or injection, resins, dyes and plastics in cosmetics and in wearing apparel, and chemicals handled in occupational activities may have related immunochemical groupings that may predispose to cross-sensitization. In this manner existing dermatitis may be prolonged or aggravated or new attacks of dermatitis may result.

I recently reviewed the records of 187 patients with dermatoses I considered appropriate for the local application of antihistamine preparations and for whom thephorin ointment was prescribed. Thirty-nine per cent were recorded as failures because of lack of benefit or aggravation of symptoms. In 11.5 per cent of the total number (187), dermatitis venenata developed from the therapy and in several instances this was severe and protracted. Because of these sensitizing potentialities we advise emphatically against the local use of antihistamines for the relief of itching and inflammation in contact dermatitis. We have been disappointed likewise in the response to antihistamines in these cases when administered orally, although they are sometimes benefiicial.

Oil Dermatitis and Folliculitis

Resins, waxes, and oils are important and frequent causes of industrial dermatitis and folliculitis and will therefore be reviewed.

Synthetic resins are used in airplane and automobile manufacture, in the wearing apparel industry, and in numerous other activities, such as the manufacture of plastic materials, varnishes, finishes, gears, insulators, condensers, and wire insulation. The most important are the urea-formaldehyde, the phenol-formaldehyde, and the coumarone resins. They produce dermatitis venenata of the sensitization type and patch testing is therefore helpful in diagnosis. Treatment is that of dermatitis venenata, adequate cleansing of skin and clothing and preferably change of employment. Oils used in curing resins frequently cause oil folliculitis.

Synthetic waxes, of which the chief ones are chloronaphthalens and chlorodiphenyls, are used in the manufacture of insulators, paints, varnishes and lacquers, and in transformer oils. The skin lesions caused by the waxes are acneform folliculitis and furunculosis due to mechanical plugging of follicles and secondary infections. Patch tests are therefore negative. The lesions may not be confined to exposed parts, since the fumes produced in their manufacture may penetrate the clothing. Serious systemic symptoms may result from inhalation. The treatment is that of folliculitis. Prevention is chiefly a matter of industrial hygiene and concerns ventilation, control of fumes, and use of protective devices, and of personal hygiene as regards adequate and frequent cleansing of skin and work clothes.

Skin eruptions caused by cutting oils, cutting compounds, and lubricants are among the most important dermatoses because of their frequency. They are always prevalent in machine industries and may constitute from 10 to 15 per cent of dermatoses in a statistical survey. They are particularly prevalent and troublesome in times of accelerated industrial activity and among new employees. The lubricating oils and greases are usually petroleum derivatives. The cutting oils are divided into straight or *insoluble oils* and soluble oils or *cutting compounds*. The insoluble cutting oils are usually combinations of mineral, vegetable, and animal or fish oils. The cutting compounds are sulfonated oils, soap oils, and phenolated oils. The sulfonated oils are made with castor oil, cotton-seed oil, and olive oil treated with sulfuric acid and neutralized with common salt or an alkali. The soap oils are made by saponifying insoluble oils and then mixing them with water to form a creamy emulsion. The phenolated oils are made by adding carbolic acid to mineral oil, paraffin oil, or kerosene. Sulfur and chlorine are frequently added to vegetable or animal oils to improve lubrication of cutting edges by increasing film strength and to prevent the oils from becoming rancid. The potentiality for dermatitis in these various mixtures should be evident.

The cutting oils, lubricants, and greases are not primary irritants but cause dermatitis through sensitization reactions. Frequently their chief action is a defatting effect. Mineral oil in particular absorbs the natural sebum of the skin which results in drying and cracking. This renders the skin more susceptible to dermatitis from other sources, such as the cleansers used after work and chemicals with which contact is made at or when off the job. Cutting oil dermatitis manifests itself as a diffuse erythematous process with edema and later with moderate desquamation, dryness and fissuring, or as a follicular dermatitis with numerous small papules or small vesicles. When confined to sharply defined patches and exhibiting numerous small vesicles, it may be readily mistaken for fungous infection.

More common than oil dermatitis in this field is folliculitis caused by plugging of hair follicles with oil, grease, and dirt and consequent inflammation and pyogenic infection. This folliculitis occurs most frequently on the ulnar aspect of the hands and forearms which rub over oily surfaces. It is also observed on the anterior surfaces of the thighs and knees and occasionally on the abdomen, because the skin in these latter areas is frequently in contact with oil soaked clothing. The skin surfaces are studded with small black dots, indicating the plugged follicles, and among them are scattered inflammatory papules, papulo-pustules, and occasional furuncles. Non-industrial folliculitis and furunculosis do not exhibit this characteristic and diffuse follicular plugging nor the restriction of pustules and furuncles to such sites.

Acneform eruptions of the face, particularly in young men and young women, have been observed in heavy cutting and grinding activities when cutting oils containing a high percentage of chlorine have

been used and particularly when the grinding operations, as in gear cutting, have exposed the workers faces and necks to an oily mist. This condition, chloracne, is characterized by small cystic papules and nodules containing straw colored fluid, by follicular hyperkeratosis and plugged pores. These features, and the history of exposure, serve to differentiate it from non-occupational acne.

Rarely keratoses, papillomas, and even epitheliomas are observed after prolonged contact with petroleum oils. These conditions are more apt to follow prolonged exposures to coal tar and pitch, especially when there has been an associated sensitization by exposure to the sun.

The oils are only indirectly responsible for the development of infections. These occur as a complication of dermatitis and particularly follicular plugging. The infections follow contact with pyogenic bacteria in shop dirt, cleaning rags, dirty clothes and miscellaneously contaminated skin. Fine metal particles in used oil, waste, and rags frequently cause cuts and abrasions which serve as portals of entry for infection. Sterilization of the oils is therefore not necessary in the prevention of oil folliculitis, but oil should be changed when rancid. Used oil should be filtered and centrifuged before re-use to remove metal particles and dust.

Attention should be directed chiefly to the necessity for personal cleanliness of skin and clothing and the desirability of keeping machines and the working environment neat and clean. Adequate lavatory facilities and clothes lockers should be provided.

Individuals with dry or an ichthyotic type of skin should not be employed in machining and similar industries, or they should be provided with protective sleeves and aprons of materials impervious to oil and with protective creams made with vegetable or animal oils and containing wetting agents for more ready removal. Sulfonated castor oil or a similar cleanser is a more satisfactory cleanser than toilet soap. Degreasing agents, such as solvents, must not be used as cleansers.

Oil dermatitis should be treated similarly to other types of contact dermatitis but with special consideration for the nature of the causative irritant, its mode of action, and the neutralization of its effects. The infections should be treated with bactericidal and bacteriostatic agents such as potassium permanganate or mercury biochloride compresses and ammoniated mercury, bacitracin, or neomycin ointments, and in severe cases with sulfonamides by mouth or penicillin by injection. Pustules should be punctured and evacuated.

(The second and final part of Doctor Foerster's paper will be published in the December issue of The Journal.)

LECTURES TO BE PRESENTED AT VA CENTER, WOOD

Two outstanding specialists will lecture during November 1952 at the VA Center, Wood, under the auspices of the combined neuropsychiatric staffs of the Veterans Administration, Regional Office, Milwaukee, and the Veterans Administration Center, Wood. Medical professional people are invited. The lectures are as follows:

EXPERIMENTAL NEUROSES

By Jules H. Masserman, M. D.

The lecture will be held November 19, at 8:00 p.m., in the Ward Memorial Theater, Wood.

Doctor Masserman will illustrate his talk with a new motion picture. The doctor is well known to all psychiatrists in this area. He is associate professor of nervous and mental diseases, Northwestern University; scientific director, National Foundation for Psychiatric Research; consultant, Secretariat of the United Nations; and chairman of the Dean's Sub-Committee for Psychiatry; VA Hospital, Downey, Illinois. He is the author of "Principles of Dynamic Psychiatry."

ENDOCRINES AND EMOTIONS

By Francis J. Braceland, M. D.

This lecture is to be held November 25, at 8:00 p.m. in the Hospital Theater of the General Hospital, Wood.

Doctor Braceland is at present the psychiatrist in chief of The Institute of Living, Hartford, Connecticut. In the past he has served as dean of the School of Medicine, Loyola University, Chicago; professor of psychiatry, Mayo Foundation Graduate School; consulting psychiatrist to the Mayo Clinic; chief of the neuropsychiatric division, U. S. Navy; consulting psychiatrist to the Surgeon General, U. S. Navy; secretary-treasurer, American Board of Neurology and Psychiatry; and consultant to the medical advisory board of the Veterans Administration.

Surgical-Medical Staff Conference*

Some Consequences of Depletion of Sodium Chloride

By WILLIAM W. ENGSTROM, M. D.**
Wauwatosa

BECAUSE patients subjected to surgical procedures tend to conserve sodium chloride in the postoperative period, the evil consequences of overloading these individuals with saline has been repeatedly emphasized. Consequently, glucose in water has become the fluid of choice in this situation. Unhappily, like most rules of thumb, this scheme of therapy is not uniformly applicable. Under certain circumstances serious salt depletion can quickly develop with this regime of treatment. Many cases could be cited as examples, but the case to be presented clearly reveals most of the complications encountered in states of salt depletion from any cause (injudicious use of low-salt diets, mercurial diuretics, etc.). Cases similar to it are frequently encountered by the practicing physician.

Case History

The patient, J. J., a 62 year old white male, was admitted to the Milwaukee County Hospital on June 12, 1951. He was acutely ill with vomiting and abdominal pain of 24 hours duration. He was dehydrated, febrile (102 F.), and had tenderness in the right upper quadrant. His blood pressure was 166 mm. mercury systolic and 90 mm. diastolic. History revealed recurrent episodes of similar, but milder attacks; these were quite typical of recurrent bouts of cholecystitis and cholelithiasis. Except for slight jaundice (icterus index 18) the blood chemistry determinations were normal, the nonprotein nitrogen was 36 mg. per cent, chlorides 101 milliequivalents per liter, and carbon dioxide 27 milliequivalents per liter (59.4 volumes per cent). It was felt that the patient should be treated conservatively until his general condition improved. Consequently he was treated with intravenous fluids and antibiotics.

His condition greatly improved and on June 22, 1951, a cholecystectomy was performed without incident. Numerous stones were present in the gallbladder. A T-tube was inserted in the common bile duct, and gastric suction was instituted.

Between June 22 and June 26 (4 days) he was able to take small amounts of fluids orally, he was given one liter of 5 per cent glucose in water daily, the gastric suction was continued until the third day, and between 200 and 450 milliliters of bile were drained from the T-tube daily. On June 27 the patient appeared lethargic and weak, nausea and vomiting occurred, and the nonprotein nitrogen was found to be 71 mg. per cent. Similar complaints were present on June 28; his blood pressure had fallen to 96 mm. systolic, and 60 mm. diastolic. The output of urine was 500 milliliters for the 24 hour period. The drainage of bile continued at the same rate. Because of apparent subcutaneous desiccation he was given 2 liters of 5 per cent glucose in water on this day. On the following day, seven days after the operation, his condition was critical. The patient was mentally confused, weak, dehydrated and had shallow respirations. He did not complain of thirst. The blood pressure was 72 mm. systolic and 54 mm. diastolic. The nonprotein nitrogen had risen to 86 mg. per cent, the serum chlorides had fallen markedly to 61 milliequivalents per liter, the serum bicarbonate was normal (28 milliequivalents per liter) and, as expected, the serum sodium was low, *i.e.* 125 milliequivalents per liter (normal: 135 to 145 milliequivalents per liter.)

In the next 24 hours the patient was given 5 liters of physiologic saline, 3 liters of which contained 5 per cent glucose. No other therapy was instituted. By the following morning (June 30) he looked and felt much better. The nausea and vomiting had stopped; the blood pressure had risen from shock-like levels to 120 mm. systolic and 58 mm. diastolic. The serum chloride was 87 milliequivalents per liter. During the next two days he was given 3 liters of physiologic saline daily with steady improvement. On July 3, 1951, four days after instituting treatment with sodium chloride, the nonprotein nitrogen had fallen to normal, 27 mg. per cent; he felt well and was able to be up in a chair.

Discussion

The clinical manifestations exhibited by this patient prior to proper therapy are typical of that of the salt-depletion syndrome. The manifestations were entirely alleviated by no other therapy than the administration of salt solution. The syndrome is characterized by weakness and apathy, mental changes, subcutaneous desiccation, anorexia which frequently leads to nausea and vomiting, absence of thirst, a fall in blood pressure, and impaired renal function. A brief discussion of these manifestations is pertinent.

In simple dehydration from lack of water alone the extracellular fluid and blood volumes are largely

*The following papers by Doctors Engstrom, Garland, and Shaiken were given as part of a surgical-medical staff conference presented by the staff of Milwaukee County Hospital at the One Hundred and Tenth Annual Meeting of the State Medical Society of Wisconsin Milwaukee October 1951.

**Assistant professor of medicine, Marquette University School of Medicine.

maintained; circulatory failure usually does not occur until very late. Because of the primary dehydration the extracellular fluids tend to become hypertonic. On the other hand when salt depletion occurs, the extracellular fluid becomes hypotonic from loss of electrolyte (exemplified by hypochloremia and hyponatremia) and marked contraction of this space occurs. The blood volume falls and peripheral vascular collapse ensues. The kidney, at least for a time, continues to excrete water (about 500 to 700 milliliters per day) in an effort to maintain the tonicity of the body fluids. For this reason the record of the output of urine may appear fairly good even though the patient is becoming progressively worse. It should be noted that on the day before therapy was started, the patient under consideration excreted 500 milliliters of urine. But, as the salt depletion and circulatory failure worsen, renal function is impaired, nitrogenous products accumulate in the blood, and oliguria or even anuria may develop. Death, under these circumstances, is usually attributed to "uremia" or "circulatory failure" while, in reality, the individual dies merely from a lack of salt.

Because hypertonicity is the stimulus for the development of the sensation of thirst, it is clear why the salt-depleted patient is not thirsty. He may be severely dehydrated as a secondary consequence to the lack of salt, but his body fluids are hypotonic. Thus in dehydration where salt losses have been greater than water losses, the lack of thirst can not be taken to mean that the patient does not need water, as well as salt. The sensation of thirst is a protective device for simple lack of water; no such device exists for lack of sodium chloride.

The patient whose case history was presented developed nausea and vomiting; these symptoms promptly disappeared as soon as his salt needs were largely replaced. It is not clear why vomiting appears in these patients although it may be from pylorospasm and gastric distension. In any event when vomiting appears, salt losses are aggravated and a vicious circle develops.

In this case the cause of the development of the salt-depletion syndrome is quite obvious. The patient lost sodium and chloride from the biliary drainage and chloride from the gastric suction and vomiting. During this period only water was replaced. His difficulties could have been prevented had the chemical nature of the bile and gastric fluids been recalled and saline administered. When water without salt is unwittingly administered to these individuals, they rapidly deteriorate because hypotonicity is aggravated, and, although they are secondarily dehydrated, the body can not retain water without salt.

In certain cases the problem of electrolyte therapy may be complex and involve problems of disturbed acid-base balance, multiple ion deficiencies, and nutrition. These problems can not be discussed here. But, at least when confronted with a dehydrated patient the question must be raised whether he needs water alone or water with salt. If he has been or is losing fluids from the gastrointestinal tract, he will surely need sodium chloride. If his renal function is not too seriously impaired, the kidney will correct for moderate disturbances in acid-base balance. Laboratory tests may be very helpful and add precision to diagnosis and therapy. However, the history of the events which led up to the disability may be even more informative, especially with regard to the total needs of water and electrolyte.

Summary

A case of salt depletion is presented to re-emphasize the general importance of the syndrome. The disorder was characterized clinically by weakness, apathy, mental confusion, nausea, vomiting, dehydration, a lack of thirst, a failing circulation, and impaired renal function. Laboratory studies revealed a low serum chloride and sodium and an elevated nonprotein nitrogen. Treatment with physiologic saline alone corrected these disturbances in a few days. The syndrome may develop quite acutely if water without salt is administered when losses of sodium and chloride continue.

Milwaukee County General Hospital.

Incisional Hernia

By JAMES G. GARLAND, M. D.*

Milwaukee

L. K., a 69 year old pallid man, had an obvious large incisional or postoperative ventral hernia in the epigastrium. A large transverse oval defect was felt in the fascia, and several surgical scars were seen. The hernia appeared many months after the surgical closure of a perforated peptic ulcer which had been complicated by postoperative wound infection. This man had had four operations for complications of a peptic ulcer: obstruction, and twice for perforation.

The patient's present complaint was severe, intermittent epigastric pain and a 50 pound weight loss in the past year. He was constipated, had nocturia, and a chronic cough. His symptoms of pain were not from his incisional hernia, but from a marginal ulcer. The hernial defect in the fascia was so big that there was no danger of incarceration or obstruction. The treatment here, then, was to dis-

* Associate clinical professor of surgery, Marquette University School of Medicine.

regard the hernia and treat the cause of his complaints. Surgery was not indicated on the hernia.

Incisional hernia is unfortunately common. Of over 4,000 patients with various types of hernia examined at the Milwaukee County Dispensary in 10 years (1936-1945), 390 patients, or 9 per cent, had incisional hernia. Most of these patients were past middle age, many were heavy, and women outnumbered men two to one.

The usual course is that local pain and a local tender area are found after an abdominal incision is healed. Weeks or months later a bulge with an expansile impulse on cough is felt. The hernia gradually increases in size, as does the defect in the fascia forming the hernial ring. Omentum adheres to the sac early. There is a mushroom-like spread of the hernia beneath the subcutaneous tissue. The sac may be multi-loculated, and often the hernial defect is multiple. The hernia may become irreducible or even strangulated. The skin over a large hernia may become irritated. The defect in the fascia at the hernia tends to be transverse above the umbilicus, and surgical repair is easier transversily; whereas, below the umbilicus, the defect tends to be vertical and can usually be best repaired in that plane.

Why do incisional hernias occur? There are causes which may be attributed to the patient and also those associated with surgery. Factors in the patient are either mechanical or delay in healing. Mechanical factors are obesity, coughing, or straining; delay in healing factors are anemia, dehydration, hypoproteinemia, and deficiency in vitamin C. The latter are usually found in cachectic patients, those with carcinoma, and in patients with complications of a peptic ulcer.

Factors associated with surgery are the incision, the closure, the suture material, and the hospital course. Mid-line incisions are commonly followed by a hernia. When two or more nerves of the wall are cut at surgery, muscle atrophy usually follows and an incisional hernia will appear. The abdominal wall receives its nerve supply from 6 to 12 thoracic and first lumbar from the right and left sides. The nerves lie between the internal oblique and transversalis muscles and penetrate the rectus sheath laterally and extend medially on the anterior surface of the posterior rectus sheath and enter the rectus muscle near the mid-line of the abdomen. Anatomical incisions that spare the nerves (for example, McBurney, transverse, and Pfanensteil) are rarely followed by a hernia. Paramedian incisions are more often followed by a hernia because of the difficulty in good c l o s u r e of the tense posterior sheath. Non-anatomical incisions, chiefly the rectus muscle splitting and mid-line, are most frequently followed by a hernia.

Gentle handling of tissue and not too much tension on the incision during surgery are conducive to good healing. It is imperative that the peritoneum be well approximated and not to incorporate any omentum in the sutures. The posterior rectus sheath must be closed well to avoid a hernia. Hematoma in a wound may delay healing, spread fascia edges, or become infected. Care in the hemostasis is, therefore, important.

In wound healing the sutures are the only support for the first four days. On about the fourth day, fibroblasts appear and multiply. By the eighth to tenth day, the wound has reached almost its maximum strength. By the fourteenth day, the sutures are not needed. Sutures that are too tight will tear through. Continuous sutures may have this effect unless placed with care. Plain catgut, especially larger sizes, causes a prompt foreign body reaction and delays healing. Chromic catgut, especially in fine size, causes much less foreign body reaction and does not delay healing. Interrupted non-absorbable sutures like silk or cotton cause almost no reaction and do not delay healing. Early ambulation hastens wound healing. Healing is markedly delayed by deficiency in protein and vitamin C.

Since there is no tendency for regressing but rather a progression in size of an incisional hernia, the treatment is surgical, provided the patient is prepared well and there are no contraindications. Despite the large size of the defect, some become irreducible, and, if acute, require emergency surgery. About 20 per cent of the patients I have operated on for incisional hernia came to surgery as an emergency. These were elderly, poor-risk patients with strangulation of the hernia; there was a 25 per cent mortality in this group. There were no deaths in the elective surgery group; one should not wait until strangulation of the hernia has developed.

At surgery, the sac should be opened carefully, the adherent contents freed, and then the inner side of the abdominal wall explored for other small hernial defects. Two, three, or even four defects may be present. By recognizing and repairing any other defect at this time, likelihood of recurrency will be reduced after excising the sac. Then approximate the peritoneum well and re-approximate the wound in anatomical layers. If this cannot be done, embrocate two layers of fascia over the defect. Where the defect is too large, or the tissue inadequate, repair may be done by swinging a flap of fascia, burying a dermal graft under tension, or using tantalcum mesh.

In conclusion, the commonest causes of incisional hernia are faulty closure of the wound, division of nerves of the abdominal wall, and postoperative wound infection. By avoiding these three pitfalls at surgery, incisional hernia will be greatly reduced. If a hernia appears, surgery is usually indicated.

324 East Wisconsin Avenue.

SURGICAL–MEDICAL STAFF CONFERENCE

Bleeding Peptic Ulcer

By JOSEPH SHAIKEN, M. D.*

Milwaukee

THE patient, a 68 year old male, was treated at the Milwaukee County Dispensary for gastric distress. His main complaints were intolerance for fatty and fried foods and bloating. At the dispensary roentgen studies of the gastrointestinal tract were normal. The gallbladder did not visualize. The patient's progress was unsatisfactory, and he was admitted to the Milwaukee County Hospital for further studies.

On the fifth day of his hospital stay he developed tarry evacuations. A routine fluoroscopic and x-ray study of the upper digestive tract was done the next day. These studies revealed a prepyloric gastric ulcer. On the day of the examination the patient had five tarry evacuations.

The patient was treated for hemorrhage. The pulse and blood pressure were checked at regular intervals. Three whole-blood transfusions were given. The blood count which revealed a red blood cell count of 2,100,000 returned to 4,100,000 within a week. The patient was given multiple small feedings.

At the end of 10 days the roentgen studies showed some improvement in the appearance of the gastric ulcer. Surgical removal was recommended because of the location of the ulcer.

The most frequent cause of gross hemorrhage from the upper digestive tract is peptic ulcer. In the management of the patient with this type of hemorrhage, observations of the pulse and blood pressure are important to evaluate the patient's progress and should be done at first every 15 to 30 minutes and later at hourly intervals.

The routine blood studies, blood count, and plasma cell ratio are done promptly. These studies are not conclusive at first because of hemoconcentration. In a few days, after replacement of lost fluids, a more accurate picture of blood loss becomes apparent.

A blood urea nitrogen examination done daily will usually indicate if hemorrhage has ceased and may indicate recurrent bleeding. A blood urea nitrogen of 20 to 50 mg. per cent is usually present the day after hemorrhage and this may drop to a normal level of 15 mg. per cent in 24 to 48 hours. If after the blood urea nitrogen has become normal it again becomes elevated, recurrent bleeding should be suspected.

One of the important recent advances is the early roentgen examination of the bleeding ulcer patient. Formerly it was thought at least 10 days to 2 weeks should pass before doing stomach x-rays. The period was then shortened to one week. Most recently, x-ray studies have been done within 24 to 48 hours after a hemorrhage without deleterious effects. The studies have revealed the presence of an ulcer in many patients. In some of these, x-ray studies 10 to 14 days later revealed no demonstrable ulcer.

The explanation of the failure to determine the etiology in many patients with gross hemorrhage may be due to rapid healing of the lesion as evidenced by these studies.

If the diagnosis of the source of bleeding has not been made, greater attempts at establishing a diagnosis should be made with liver function studies like the bromsulphalein test for dye retention and esophagoscopy to rule out esophageal varices.

In recent years the prompt feeding of the patient with a bleeding ulcer has become generally accepted. This does not mean that the patient has to be met in the admitting room with a tray of food. It means merely that if the patient is not in shock, is not nauseated or vomiting that food ordinarily prescribed in ulcer treatment may be given in small amounts at regular intervals. These feedings may not be started in some patients for 12 or even 24 hours after admission to the hospital, but the principle of early feeding is now well established.

In patients with massive hemorrhage where the usual methods of medical treatment and blood replacement are not keeping pace with blood loss and in those patients with a reasonable diagnosis of peptic ulcer, surgical treatment may have to be resorted to, but it should not be an exploratory operation.

Surgery is indicated only if the diagnosis of peptic ulcer is fairly evident either from recent roentgen studies or present studies.

In general from a personal observation of over 200 patients with gross hemorrhage from peptic ulcer, the medical therapy of this complication is very successful. The average patient with a bleeding peptic ulcer responds quite readily to the usual medical measures.

Summary

Careful observations of blood pressure, pulse, blood counts, blood urea nitrogen studies together with blood replacement and prompt feeding are the general principles of management of bleeding peptic ulcer. Blood replacement is most important in the treatment.

Early diagnostic studies, the bromsulphalein dye test, esophagoscopy, and early roentgen examination within 24 to 48 hours are helpful in evaluating the problem.

Surgery must be reserved for the hemorrhage which is not being controlled by medical measures and in the patient in whom a diagnosis of peptic ulcer is fairly certain.

* Associate professor of medicine, Marquette University School of Medicine.

536 West Wisconsin Avenue.

Treatment of Anemia*

By FRANK H. BETHELL, M. D.
Ann Arbor, Michigan

ANEMIA may be defined as a state of the circulating blood in which the erythrocyte count or hemoglobin level or both are below the normal range for the age and sex of the individual. Anemia results from a failure of hemoglobin and red cell production to keep pace with loss from the circulation, or with the demands of an increasing blood volume during periods of active growth or pregnancy. Treatment of anemia requires accurate classification of the type of abnormality present, and a careful search for causative factors, such as hemorrhage, infection, malignancy, nutritional deficiency, drugs or chemical intoxication and hemolytic processes. Wherever possible, the primary objective of therapy should be correction of the underlying disorder, since anemia is always a sign of disease, never a diagnosis.

Aside from the replacement value of blood transfusion, specific measures available for the correction of anemia are designed either to supply hemopoietic factors which for one reason or another may be lacking, or to diminish excessive rate of red cell destruction. In the former category the most important agents are iron, folic acid, vitamin B_{12}, ascorbic acid, and a diet providing a well balanced intake of amino acids as supplied by proteins of good biologic quality.

The total iron content of the human body is about 4.5 Gm. of which roughly two-thirds or 3 Gm. are in the form of circulating hemoglobin. Since erythrocytes are constantly being destroyed and replaced at the rate in health of about .83 per cent daily, the hemoglobin iron turnover in 24 hours is approximately 25 mg. This amount exceeds by a considerable degree the total quantity supplied in the food, which with an ordinary good diet ranges from 12 to 18 mg. daily. Of this total only a variable fraction, usually less than 25 per cent and sometimes as little as 10 per cent, is available for absorption and utilization. It is obvious, therefore, that hemoglobin iron must be conserved and reutilized. Some iron, however, is always lost in the digestive secretions, urine, and sweat. Normal menstruation approximately doubles the iron loss, and pathologic hemorrhage may, of course, increase it greatly. The daily minimal iron absorption requirement of an adult male is about 1 mg.; that of a menstruating female and a rapidly growing child prior to adolescence is approximately 2 mg. Unrecognized hypermenorrhea is a common cause of iron deficiency and hypochromic anemia.

Dietary iron consists largely of colloidal ferric hydroxide. Its utilization is facilitated by the gastric hydrochloric acid, which acts as a solvent and permits ionization in the trivalent or ferric state. The reducing substances in food, especially ascorbic acid, cysteine, and compounds possessing sulfhydryl groups, play an important role in converting ferric to ferrous iron. It is in the latter form that the metal is most efficiently absorbed. Absorption may take place throughout the small intestine but occurs, it is believed, chiefly in the duodenum before a high degree of alkalinity promotes oxidation back to the less absorbable ferric form. Absorption is governed in part by the need for iron. This apparently is accomplished by the presence in the intestinal mucosa cells of a compound termed apoferritin, which has the property of combining with ferrous iron to form a colloidal complex known as ferritin. This is a storage form of iron which is widely distributed throughout the body, especially in the liver, and is apparently the main form in which iron is stored in the tissues. Ferritin can readily give up its iron for transportation in the plasma in the form of a compound called transferrin, which is an iron globulin complex, and for the synthesis of hemoglobin and the heme enzymes of the tissues.

Aside from dietary intake, iron absorption is influenced by the secretion of hydrochloric acid, by the emptying mechanism of the stomach, by intestinal motility, and by the extent and integrity of the absorptive surface. Impaired utilization of iron, in the presence of chronic infection, and the increased demands during growth and pregnancy contribute to the production of iron deficiency, but the most common cause of microcytic hypochromic anemia is chronic or recurrent blood loss. Without attempting to review the more usual lesions of the alimentary tract associated with acute or chronic hemorrhage, there are a few conditions often overlooked which may be asymptomatic or of vague symptomatology, but which may cause severe anemia due to occult blood loss. Worthy of mention in this connection are telangiectasia, which frequently involves the nasal and alimentary tract mucosa but may not be detected by the ordinary methods of inspection; esophageal hiatus hernia of the stomach, which is often difficult to demonstrate roentgenographically; and Meckel's diverticulum with ulceration. Hiatus hernia and Meckel's diverticulum ordinarily should be treated surgically. Telangiectasia, which may be either hereditary or sporadic, is usually a disseminated process, and corrective therapy is rarely possible. The individual may have telangiectases over the lips and nose or as conspicuous processes on the tongue.

Treatment of telangiectasia is rarely specific but may be of great benefit to the individual. It should consist of avoidance of irritation, together with the continued use of a medicinal iron preparation.

* Presented before the One Hundred and Tenth Annual meeting of the State Medical Society of Wisconsin, Milwaukee, October 1951.

With respect to specific therapy for microcytic hypochromic anemia, the use of foods with high iron content such as beef, liver, eggs, dried fruits, and molasses may be advocated, but chief reliance should be placed on inorganic iron preparations. The great majority of patients with iron deficiency will tolerate and benefit from orally administered iron in the form of ferrous sulfate, ferrous gluconate, or a preparation of colloidal ferric hydroxide (Ferrocol), preferably given immediately after meals because it is better tolerated at that time. In the presence of gastrointestinal conditions which impair iron absorption, or when circumstances preclude the use of iron given by mouth, highly satisfactory results may be obtained by the intravenous administration of preparations of saccharated iron oxide. This compound is relatively non-toxic when given according to directions, and the metal is effectively utilized for hemoglobin synthesis when anemia is due to iron deficiency. Not more than 100 mg. as elemental iron should be given in a single dose, and the total quantity employed should be based on the hemoglobin deficit, with allowance for some excess. For each gram of hemoglobin per hundred cubic centimeters of blood which it is desired to replace, 300 mg. of iron should be administered. Thus in the case of a male with a hemoglobin of 7 Gm. per hundred cubic centimeters, the difference from a normal of 15 Gm. is 8. Such an individual should receive a course of 24 injections of saccharated iron oxide each supplying 100 mg. of elemental iron. In order to minimize the possibility of severe reactions in patients who may be unusually sensitive to the drug, it is advisable to limit the dose of the initial injection to 50 mg. The intravenous use of saccharated iron oxide should be restricted to situations in which it is clearly indicated, and the administration should not be continued indefinitely, except in cases of persistent or recurrent bleeding as in hereditary hemorrhagic telangiectasia.

The pathogenesis of macrocytic anemias with megaloblastic marrow reactions has been greatly elucidated within recent years. It is now known that both folic acid and vitamin B_{12} are required for normal hemopoiesis, and that they participate in widespread metabolic processes. Folic acid is extensively distributed in natural foods, chiefly in conjugated forms. The release of the free vitamin from its conjugate requires enzymatic action performed by conjugases. Since folic acid is believed to be absorbed only when it is in the free state, deficiency may result from failure of conjugase action in the alimentary tract or elsewhere in the tissues since there is reconjugation for storage purposes. Recently, evidence has been obtained that the biologically active form of folic acid is probably a closely related chemical compound, which because of its microbiologic growth promoting properties has been termed the L. citrovorum factor. Other names which have been proposed for this compound are Leucovorin and Folinic acid.

The conversion of folic acid to the L. citrovorum factor in living tissues is facilitated by ascorbic acid. Ascorbic acid apparently plays a role in hemopoiesis both in the metabolism of folic acid and in the utilization of iron.

Vitamin B_{12} in the form originally isolated by Rickes and associates in the United States and by Lester Smith in England is now known to be but one of a group of related compounds for which the generic term cobalamin has been proposed by its American discoverers. The United States Pharmacopoeia designation of the official preparation of vitamin B_{12} is cyanocobalamin. The vitamin B_{12} analogues are naturally present chiefly in sources of animal protein, but it is probable that in man appreciable quantities may become available through intestinal bacterial synthesis. On the other hand, certain bacteria including some strains of E. coli require for their growth an exogenous source of B_{12} and so, if inhabiting the proximal portion of the small intestine, they may deprive the host of the vitamin. It has been conclusively demonstrated that the dietary extrinsic factor of Castle is vitamin B_{12}, or one of its analogues. The chemical nature of the intrinsic factor has not been elucidated, nor is the mode of interaction of the intrinsic factor and the extrinsic factor completely understood. It is generally believed that intrinsic factor is a protein with enzymatic properties which is secreted by the gastric and duodenal mucosa. Evidence has recently been presented that intrinsic factor may combine with vitamin B_{12} to form a microbiologically inactive complex, thereby in some manner facilitating the absorption of the vitamin, perhaps by preventing its utilization by coliform organisms.

In Addisonian pernicious anemia the primary defect appears to be lack of intrinsic factor resulting thereby in a conditioned deficiency of vitamin B_{12}.

Deficiency of vitamin B_{12} from dietary lack of cobalamin appears to be a less common cause of nutritional macrocytic anemia than deficiency of folic acid. Chronic intestinal disorders including idiopathic steatorrhea, disseminated ileitis, partial obstruction, and diminished absorptive surface resulting from short circuiting or resection of small intestine may lead to impaired absorption of both vitamin B_{12} and folic acid. Patients who survive for several years after total or subtotal gastrectomy are prone to have a syndrome indistinguishable from pernicious anemia develop, and which may include the characteristic neurologic changes seen in true pernicious anemia. Specific measures available for the treatment of macrocytic megaloblastic anemias include liver extract, desiccated stomach, vitamin B_{12}, and folic acid. The effectiveness of refined liver extracts is apparently due mainly, if not entirely, to their content of vitamin B_{12}. Clinical experience indicates that vitamin B_{12} usually constitutes a complete form of replacement therapy for pernicious anemia when administered intramuscularly in doses of 10 to 30 micrograms at intervals adjusted to in-

dividual needs. In the third supplement to the fourteenth edition of the United States Pharmacopoeia the U.S.P. unit as a measure of antipernicious anemia activity of injectable liver extracts is dropped and such extracts are standardized according to their content of vitamin B_{12} activity employing cyanocobalamin as the reference standard. In other words, they are assayed microbiologically instead of by clinical tests. The U.S.P. unitage for oral liver and stomach preparations based on clinical trial is retained. Treatment of macrocytic megaloblastic anemias other than pernicious anemia is directed primarily toward the underlying disorder if this is correctible. Alleviation of dietary folic acid deficiency usually may be accomplished by the oral administration of 10 mg. daily. The parenteral route should be reserved for patients with intestinal disease. Orally administered vitamin B_{12} in daily dosage of 5 to 10 micrograms may be effective in correcting macrocytic anemia due to dietary lack of this vitamin when pernicious anemia can be excluded with reasonable certainty by the finding of gastric hydrochloric acid.

In the presence of multiple deficiences, especially in the presence of chronic active intestinal disease, crude liver extract given by injection, together with folic acid, may be of value.

The many complex and expensive mixtures which have been advertised for the treatment of anemias appear to have no place in the rational treatment of such disorders. There is no such thing as a complete hematinic, and so-called synergistic therapy for anemia is a euphemism for shot-gun therapy. The shot-gun method is inefficient, wasteful, and tends to blunt diagnostic acumen. It is not meant to imply that more than one deficiency may not be present in an individual case. They should be sought for, identified, and treated rationally with whatever substances may be needed.

In contrast to the anemias caused by diminished or defective blood formation are the hemolytic conditions in which there is increased rate of destruction of the circulating erythrocytes. Such anemias as a rule are normocytic and normochromic, although macrocytosis is not uncommonly observed associated with a normoblastic marrow reaction rather than a megaloblastic reaction of the pernicious anemia type.

The hemolytic nature of a chronic anemia may be overlooked and the patient subjected to a long period of ineffective therapy. Although a wide variety of hereditary and acquired forms of hemolytic anemia are known, special interest attaches to the so-called idiopathic acquired hemolytic anemia usually associated with the presence of demonstrable circulating antibodies of the so-called incomplete type. This entity, or group of related entities, appears to have become more common in recent years and, in any event, is recognized with greater frequency. Splenectomy may be an effective form of treatment of idiopathic acquired hemolytic anemia, but the results are far less uniformly favorable than in cases of hereditary spherocytic hemolytic anemia of the congenital hemolytic jaundice type.

Now that the therapeutic field of usefulness of ACTH and cortisone is being more clearly evaluated, one of the disorders in which these hormones have proved of real merit is idiopathic acquired hemolytic anemia. In this condition ACTH or cortisone may terminate an acute crisis, enable splenectomy to be performed with a reasonable degree of safety, and may even induce long-lasting complete remissions without other therapy and without need of continuous administration of the hormone.

In summary, treatment of anemia requires accurate classification as to type and careful search for underlying conditions. Correction of the primary disorder, if possible, is of paramount importance. Specific measures employed in treating anemia depend upon the nature of the disturbance as revealed by the history, physical examination, hematologic evaluation, and other appropriate diagnostic studies.

University of Michigan.

MARQUETTE OFFERS POSTGRADUATE COURSE ON FRACTURES

Marquette University School of Medicine will sponsor a postgraduate course on fractures on six Wednesday afternoons, November 12 to December 17. All sessions will be held at Marquette, except that on December 10, which will be held at the Veterans Administration Hospital, Wood.

The scheduled program is as follows:

November 12—**General Principles**—H. C. Schumm, M. D., clinical professor and director of the division of orthopedic surgery.
November 19—**Hand, Wrist and Forearm**—J. O'D. McCabe, M. D., clinical instructor.
November 26—**Elbow and Humerus**—F. G. Gaenslen, M. D., clinical instructor.
December 3—**Clavicle, Scapula, Spine and Pelvis**—P. J. Collopy, M. D., clinical instructor.
December 10—**Hip and Femur**—P. L. Carnesale, M. D., assistant clinical professor.
December 17—**Knee, Lower Leg and Foot**—Doctor Schumm.

Further information may be obtained by writing to the Director of Postgraduate Programs, Marquette University School of Medicine, 561 North Fifteenth Street, Milwaukee 3, Wisconsin.

This course will provide 9 hours of formal credit necessary for continued membership in the Wisconsin Academy of General Practice.

Pathology of Carcinoma of the Lung*

By W. A. D. ANDERSON, M. D.
Milwaukee

THE problem of pulmonary carcinoma is undoubtedly one of the most serious in the cancer field. Increase in incidence and difficulties of diagnosis and therapy make it a major public health concern. Carcinoma of the lung is now one of the most frequently seen malignancies.

Among 750 autopsies at St. Joseph's Hospital in Milwaukee, 20 instances of carcinoma of the lung were found, an incidence of about 2.7 per cent. Only in the colon and rectum was cancer seen more often. In a 1940 survey of over 93,000 autopsies cancer of the lung occurred in about 1 per cent, and it accounted for 9.4 per cent of all cancers found.

The startling increase in the incidence of pulmonary cancer during the first half of the twentieth century is well known, and is real, and not merely apparent as William Boyd, Fried, and others tried to prove. The longer life span and the greater exactness of diagnosis today will not entirely explain its present high rate. This is borne out by Steiner's recent report on almost 37,000 autopsies performed from 1918 to 1946 at Los Angeles County Hospital, which showed that the increase is real, absolute, and greater than the increase in cancer in general.

Etiologic Factors — The etiology of bronchogenic carcinoma is unknown. While there is evidence that bronchogenic carcinoma is an occupational hazard in certain cobalt mines in Europe (apparently due to radioactivity of the ore) and in the chromate industry in this country, this does little to explain the high incidence in the general population. The evidence that tobacco smoke, pulmonary viral infections, and coal tar products as used on roads are possible etiologic factors is not conclusive.

Pathologic Types

The majority of pulmonary cancers can be divided into three gross types: hilar, peripheral, and apical.

(1) *The hilar type* originates in a main bronchus or a large branch at or not far from the root of the lung, where it is accessible to bronchoscopic inspection. About 85 per cent of bronchogenic carcinomas originate in this location. In its growth the tumor thickens the bronchial wall, narrows the lumen, and may extend not only into lung parenchyma but to peribronchial lymph nodes and adjoining mediastinal structures. As a result of bronchial damage and narrowing, bacteria are retained within the lung and give rise to bronchopneumonia, purulent bronchitis, lung abscess, bronchiectasis, pulmonary fibrosis, etc., and these secondary changes may dominate and obscure the picture of carcinoma.

(2) *The peripheral* or bronchiolar type originates at the periphery in a small branch of a bronchus. These tumors are often beyond the reach of the bronchoscope.

(3) *The apical* or superior pulmonary sulcus tumor may extend to the neck, invade brachial plexus, and give rise to a characteristic syndrome.

The majority of primary cancers of the lung undoubtedly arise from the epithelium of the bronchi. While histologic variability (pleomorphism) is one of the characteristics of pulmonary cancer, they may roughly be classed into three main types: squamous cell carcinoma, columnar cell or adenocarcinoma, and small cell or undifferentiated carcinoma. Claims made for specific locations of tumors of the various histologic types, and for selectivity in the time and site of metastasis, have not been supported by most of the evidence and have not helped in the clinical appraisal of the patient. "The time of diagnosis of the lung tumor appears of more prognostic significance than the type of cell found in the tumor or its location in the lung."[8]

Special Varieties

Certain special varieties of pulmonary tumors, although less frequently seen, are of considerable interest.

Bronchial Adenoma, a distinct tumor entity, occurs at a younger age (about 40) than does bronchogenic carcinoma and is slightly more frequent in women. Most arise in large primary bronchi, probably from bronchial mucous glands, and can be readily visualized by bronchoscopy. The tumor may be situated superficially within the bronchus or extend into the wall. Usually these tumors have the microscopic characteristics of a benign tumor, with orderly, uniform arrangement of cells and few or no mitotic figures. Carcinoid and mixed or cylindromatous types have been recognized histologically. The latter type is more frequently malignant than the former. In many cases the tumor is not completely encapsulated, and metastases in lymph nodes or other organs have occurred. Although appearing innocent histologically, it cannot be considered as benign. Nevertheless, the prognosis with bronchial adenoma is relatively good, much less serious than with bronchogenic carcinoma.

Alveolar Cell Carcinoma, another infrequent but distinctive type of pulmonary cancer, is also called pulmonary adenomatosis. An intrinsic tumor of the bronchial tree is not evident. The tumor may appear as multiple soft grey nodules throughout the lungs or as a diffuse grey infiltration. The tumor is composed of columnar cells which extend to and line the pre-existing alveoli. Extensive growth of the tumor may occur while still maintaining the alveo-

*Presented as part of a symposium on carcinoma of the lung at the One Hundred and Tenth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1951.

lar architectural outline. The clinical signs and symptoms may be those of chronic pulmonary disease with failure of the right side of the heart. Metastases occur in most cases.

This is a distinctive type of pulmonary cancer. It is more equally distributed between the sexes than are other types of pulmonary cancer. The presence of cilia and of mucus in some of the tumor cells suggests they originate in the terminal bronchiolar epithelium rather than in the alveolar lining cells, as maintained by some investigators. The term pulmonary adenomatosis has been used because of the unsubstantiated belief that in some patients it is benign, and that it is comparable to the infectious pulmonary adenomatosis of sheep and other animals. There seems little reason to consider this other than a distinctive variety of pulmonary cancer, probably arising from terminal bronchiolar epithelium. By direct spread it lines the alveoli and uses the pre-existing architecture as a supporting and nutritive framework. Whether the etiology is viral, as the pulmonary adenomatosis of animals seems to be, is another problem. The nomenclature of terminal bronchiolar carcinoma would seem to be most accurate.

The other rarer pulmonary tumors such as hamartoma, hemangioma, mesodermal tumors, and pleural mesothelioma need not be considered along with the problem of carcinoma of the lung.

Metastasis

Bronchogenic carcinoma extends most frequently to peribronchial and mediastinal lymph nodes. But also, cancer cells situated in the lung, by growth through thin-walled pulmonary veins, gain access more readily than most malignant tumor cells to the peripheral arterial blood stream. Recent experimental work has indicated that the distribution of blood stream metastasis of various tumors can be accounted for by the mechanics of the circulation and the consequent distribution of embolic tumor cells, without the necessity of considering any difference in the "soil" factor of various tissues in supporting embolic tumor growth. It is no wonder then that bronchogenic carcinoma with comparative frequency produces metastases in such organs as adrenals, kidneys, spleen, brain, and bone, and even shows up occasionally with widespread metastases in skin and voluntary muscles. In my own experience I have not seen from a visceral cancer multiple metastases in the skin and voluntary muscles of the arms and legs except from bronchogenic carcinoma.

The small cell or undifferentiated carcinoma not infrequently forms a relatively large mediastinal mass, with but comparatively little tumor within the lung tissue. This has led in the past to many of these tumors being mistakenly considered as mediastinal lymphosarcoma. This histologic type of pulmonary cancer appears to spread to cervical lymph nodes and liver with greater frequency than the squamous cell and adenocarcinomatous types.

Pathology as Related to Diagnosis

As with most cancers, successful therapy depends largely upon early diagnosis. The laboratory by biopsy or smear examination may be valuable in confirming clinical and roentgenologic evidence.

Little need be said here about bronchoscopic biopsy except to emphasize that positive biopsy diagnosis depends first of all on the skill of the bronchoscopist in reaching and removing some tumor tissue if present. Failure to find tumor in a bronchoscopic biopsy when clinical and roentgenologic findings are suggestive of carcinoma should not lead to a false sense of security, as it in no way rules out the presence of cancer.

Cytologic Diagnosis of Pulmonary Cancer

The cytologic diagnosis of carcinoma of the lung by smear examination is beyond the trial period and is established as a valuable diagnostic adjunct. In fact, of all the sites to which cytologic diagnosis of cancer by the Papanicolaou and other technics has been applied in recent years, this appears to be of most practical usefulness.

The over-all results of various workers in examination of sputum and of bronchial aspirates show no important difference in accuracy of diagnosis. A combination of both methods gives best results. Sputum examination has the advantage that it is often more easily obtained, and repeated additional specimens may be readily procured, and the laboratory may have more control over the handling of the specimen. On the other hand, patients with early lesions may not have productive cough. In such cases, bronchial aspiration is indicated and has the additional advantage of helping localize the lesion.

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561 North Fifteenth Street.

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Roentgen Aspects of Carcinoma of the Lung*

By LESTER W. PAUL, M. D.
Madison

THE roentgenologic changes caused by carcinoma of the bronchi depend upon a number of factors. The mass of the tumor may or may not be visualized. It may, and frequently does, lead to bronchial occlusion with atelectasis distal to the point of obstruction. Infection with or without abscess formation and pleural effusion may complicate the picture. Extension to the mediastinal nodes may add to the abnormal shadows present. It is obvious, therefore, that wide variations in the roentgenologic pattern may be found and that interpretation of roentgenograms may be difficult.

In order to evaluate the significance and frequency of occurrence of the various roentgen signs of carcinoma of the bronchus, my associate Dr. John Juhl and I have recently reviewed the roentgen findings in 148 proved cases seen during the past five years. Proof in all cases was obtained by bronchoscopy and biopsy, exploratory thoracotomy and biopsy, or by pneumonectomy. In the majority of cases one of the latter two procedures was employed so that either the entire lung was available for study or was inspected directly at the time of thoracotomy and a biopsy taken.

Of the 148 tumors, 83 involved the right lung and 65 the left. The distribution according to lobes was as follows: right upper, 28; right middle, 7; right lower, 23; right major bronchus, 25; left upper, 26; left lower, 21; left major bronchus, 16; lobe undetermined, 2. The male sex predominated over the female by the ratio of 9 to 1 (135 males, 15 females). The majority of the tumors were of the squamous cell type (74 cases). There were 31 cases of undifferentiated carcinoma, 20 of transitional type, 16 adenocarcinomas and seven of miscellaneous form. The average age of the patients was 56.1 years. Since this presentation is concerned mainly with the roentgen aspects of the disease, no further analysis of the clinical features will be undertaken.

We have divided the lesions into seven roentgenologic categories according to the character of the roentgen changes (Table 1).

TABLE 1—*148 Cases of Bronchogenic Carcinoma Roentgenologic Types*

Atelectasis	55	Males	133
Hilum mass and atelectasis	33	Females	15
Hilum mass	10		
Central nodular mass	8		
Peripheral mass	25	Average age	56.1
Mediastinal	2		
Miscellaneous	15		

1. *Mediastinal involvement*—Rarely, a carcinoma arising in a major bronchus or from one of the lobar bronchi spreads early in its development to the mediastinum, widely invading it and causing roentgen signs of a mediastinal mass. The tumor does not occlude the bronchus, and thus the lung distal to it does not undergo collapse. This form occurred only twice in the present series of cases. In both instances the lesions were mistaken for lymphoblastoma by the roentgenologist. Since in this type of case the primary tumor lies close to the tracheal bifurcation, diagnosis should be possible by bronchoscopy and biopsy but from roentgen evidence alone an error in interpretation is almost certain to be made for the wide lobulated shadow is hardly different from that produced by the lymphoblastomas (Fig. 1). Both tumors were of the anaplastic type.

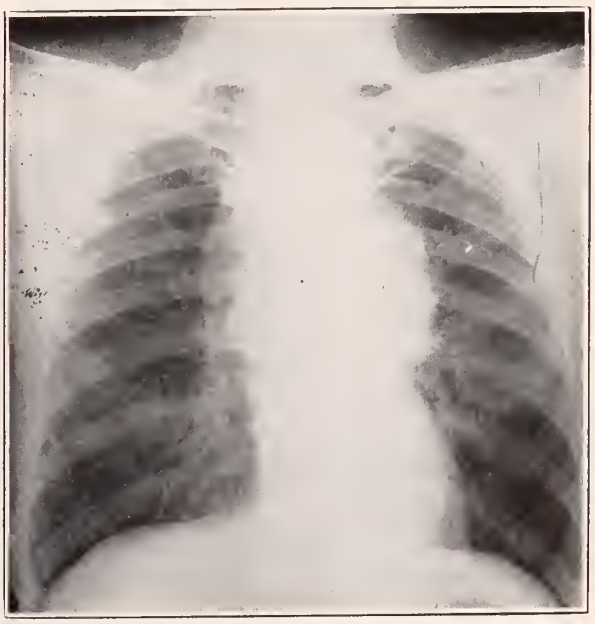

Fig. 1—Male, age 53. Large mass in central mediastinum extending to both sides of mid-line. Autopsy revealed anaplastic bronchogenic carcinoma of the left lower lobe with extensive invasion of mediastinum.

2. *Hilum mass*—Frequently mentioned in the literature as a characteristic roentgen picture of bronchogenic carcinoma is that of a mass shadow involving the hilum on one side with fuzzy outer margin or a slightly lobulated boundary (Fig. 2). The tumor arises from a major or a lobar bronchus but does not obstruct it completely. Instead it invades the adjacent lung and hilum lymph nodes. Fluoroscopic examination may show evidence of obstructive emphysema with the lung remaining distended at the end of expiration or may reveal merely a decrease in air exchange as compared to the opposite

*From the Department of Radiology, University of Wisconsin Medical School and the State of Wisconsin General Hospital.

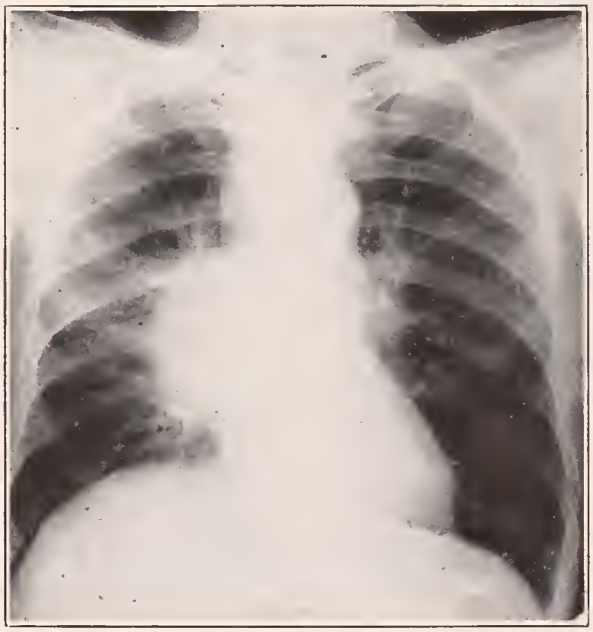

Fig. 2—Male, age 53. Large mass in right hilum. Widened upper mediastinal shadow on the right due to enlarged nodes. Bronchoscopy and biopsy. Undifferentiated carcinoma.

Fig. 3—Male, age 51. Mass in right hilum area with atelectasis of right upper lobe. Bronchoscopy and biopsy. Squamous cell carcinoma.

side. Diagnosis of this type of carcinoma is relatively easy. It is the most frequent cause of unilateral enlargement of a hilum shadow in the adult and thus, when encountered, other methods for confirming the diagnosis can be instituted without delay, including bronchoscopy and studies of the bronchial secretions for malignant cells. From a roentgenologic point of view bronchography invariably gives positive results and demonstrates clearly the deformity or obstruction caused by the tumor. This type of lesion was found in only 10 of the 148 cases, six being on the right side and four on the left. All patients were of the male sex. Four were squamous cell carcinomas, five were of transitional cell type, and one was an adenocarcinoma.

3. *Hilum mass and atelectasis*—The finding of a mass density in the region of the lung hilum plus evidence of atelectasis of a lobe or a segment of a lobe gives one of the most characteristic roentgen patterns of the disease. This combination occurred in 33 cases, being second only to atelectasis alone. In 21 cases the tumor involved the right side and in 12 the left. The majority, 19, were squamous cell carcinomas. As with the preceding type confirmatory evidence usually can be obtained from bronchoscopy or bronchography. The latter precedure invariably demonstrates the occluded bronchus without difficulty. The roentgen findings usually are so characteristic that the diagnosis can be made without difficulty and with a high degree of accuracy (Fig. 3).

4. *Atelectasis*—Atelectasis as the major roentgen finding was present in 55 cases (37 per cent). In some there were the associated changes of effusion or infection but to be included in this group the major alteration in the roentgenogram was that of pulmonary collapse (Fig. 4). The roentgen diagnosis of atelectasis offers no particular difficulty unless there is complicating infection or pleural effusion, or unless the affected area is small. In the former even the presence of atelectasis may be unsuspected, while in the latter event it may be confused with other pathologic processes, particularly pneumonia. In some of these cases the original diagnosis, clin-

Fig. 4—Male, age 29. Atelectatic density in left upper lobe. Left pneumonectomy. Squamous cell carcinoma.

ically and roentgenologically, was that of pneumonia. Failure of the process to resolve or evidence of increasing involvement of the lung or pleura eventually led to the suspicion of the presence of a tumor.

5. *Central nodular mass*—In 8 cases in this series the tumor was manifested as a bulky circumscribed mass close to the lung hilum but separated from it by a clear zone and with the mass of the tumor clearly outlined in its entirety. In most of these cases the mass was relatively large, often measuring 6 to 8 cm. in diameter and in one a central cavity with fluid level was present. The mass was seldom smoothly spherical but rather tended toward a slightly lobulated outline. Evidence of atelectasis was not found. These tumors were predominately squamous cell type (five of eight). This type of tumor offered little difficulty in diagnosis. It has been our experience that such solitary mass shadows in the adult lung are almost invariably bronchogenic carcinomas. Solitary metastatic nodules may give a rather similar roentgen appearance but single lesions of this type rarely reach the size of 4 or 5 cm. without other foci becoming evident. Bronchography is of some value in the study of this type of lesion. The occluded bronchus usually is found to be a segmental one and the sharp cut-off of the oil shadow is quite distinctive. Because of its location the tumor is seldom visualized through the bronchoscope.

6. *Peripheral mass*—The finding of a small mass shadow or area of density on or close to the pleural surface of the lung is becoming increasingly frequent chiefly as a result of the wide-spread use of photofluorography of apparently healthy individuals, and some of these will prove to be carcinomas.

When carcinoma arises from the finer subdivisions of the bronchial tree and if seen relatively early in the course of the disease, the roentgen changes will usually be limited to the demonstration of a small hazy shadow located along the periphery of the lung field or along one of the interlobar fissures some distance from the hilum. Those tumors arising in the apex of the lung tend to invade the chest wall early. In 1924 Pancoast described four cases of a tumor situated in the apex of the lung and characterized by a relatively small mass density in the roentgenogram, destruction of an adjacent rib or vertebral body, and the clinical findings of a Horner's syndrome and pain radiating down the arm. While Pancoast thought he was dealing with a specific tumor probably arising from branchial cleft remnants, subsequent reports and experiences have shown that the majority of tumors causing this syndrome were carcinomas arising from the terminal bronchioles at the apex of the lung. Carcinoma originating in the peripheral portions of the lung below the apex also show this tendency to invade the chest wall although not as early as the apical tumors nor with as great a degree of frequency. Some of these tumors have remained clinically silent for months or even years. Those occurring along the interlobar fissures are even more prone to be silent clinically until they have reached an appreciable size. In the present series, 25 were classified as peripheral carcinomas, and eight of these were discovered on routine roentgenography of the chest. In the remainder symptoms were present when the lesion was first seen. Thirteen of the tumors were on the right side and 12 on the left. Twelve were squamous cell carcinomas, 7 were undifferentiated, 3 transitional and 3 were adenocarcinomas.

When observed early, the tumor was most frequently visualized as a small hazy density along the periphery or bordering an interlobar fissure. Occasionally the density tended to be wedge shaped with the base of the wedge on the pleural surface. When followed over a period of months, the shadow sooner or later became distinctly nodular or circumscribed (Fig. 5). The nodule rarely maintained an extremely sharp rounded outline. The larger lesions were usually nodular when first seen unless they occurred along the parietes. Then the shadow was likely to be more diffusely infiltrative and, in some, rib invasion or pleural involvement was apparent.

Fig. 5—Male, age 46. No chest symptoms. Routine film revealed a nodular mass along the periphery of the right mid-lung field. Right pneumonectomy. Adenocarcinoma. The hilum nodes were involved at the time of operation.

The differential diagnosis of these small peripheral tumors is often a difficult problem. A small area of pneumonitis may appear quite similar, but the history and observation over a short period of time will usually give the answer. The most frequent lesion to be confused with a small peripheral carcinoma is an inflammatory granuloma. Many of these are circumscribed foci of tuberculosis, often referred to as tuberculomas, but others are non-specific inflammatory lesions. In an attempt to determine if there were any distinct roentgen signs by which an inflammatory nodule could be differentiated from an early peripheral carcinoma, we reviewed 21 cases

seen during approximately the same period as the cases of carcinoma being discussed. In all instances surgical removal of the lesion had been done. The nodules were almost equally divided between the two lungs, 10 being on the right and 11 on the left. The same was true of the sexes, 10 lesions being found in females and 11 in males. This contrasts sharply with the marked preponderance of carcinomas in the male sex. Most of the nodules were small, from 1 to 2 cm. in diameter. The occurrence of calcification within the mass was reported in seven specimens, but in only three was it recognized by roentgen examination. Many of the nodules containing calcification have not been operated upon since it was felt that they represented stable inflammatory lesions which did not require removal. The use of Bucky roentgenograms and planograms (body section films) is of distinct value in the study of nodular lesions since only by one of these methods can small amounts of calcium be detected. Our failure in some of these cases was due to omission of these methods of examination. The demonstration of calcium within a nodular pulmonary mass is almost certain evidence that the lesion is not a carcinoma since we have never observed it in primary bronchogenic carcinoma and it has never been reported by others to the best of our knowledge. The average age of the patients was 47 years, being about a decade less than the patients with carcinomas.

The nodules often were sharply circumscribed and smoothly rounded as one would expect from an encapsulated or inactive inflammatory granuloma (Fig. 6). In others, however, and particularly those that were not stable as shown by serial roentgen studies, the lesion mimicked carcinoma in every respect including a gradual increase in size of the nodule over a period of months.

At the present time we know of no certain roentgen diagnostic criteria for the differentiation of inflammatory and neoplastic peripheral nodules of small size except for the demonstration of calcification. Certain other findings are helpful. Small sharply circumscribed nodules less than 1.5 to 2 cm. in diameter are much more likely to be inflammatory lesions. The occurrence of such a nodule in a female and particularly below the age of 35 years is further strong evidence of an inflammatory process. It is doubtful if serial observations carried out over a period of months will be of aid since tuberculomas may increase slowly in size and carcinomas show only slight change. If the lesion should prove to be a carcinoma, valuable time has been lost and the chance for cure greatly diminished.

Other lesions also may simulate peripheral carcinoma but are much less common. These include (1) neurofibromata, (2) solitary metastatic nodules, (3) hamartomas, (4) fluid filled cysts, and (5) tumors of the ribs. Most neurofibromata occur in or close to the mediastinum and are infrequent along the periphery of the thorax. They often cause a

Fig. 6—Male, age 65. Asymptomatic nodular lesion in right mid-lung field. Calcium visible in the center of the mass. Local excision. The lesion was a fibrocaseous focus with heavy calcification in the center.

smooth pressure type of erosion of the adjacent ribs. Hamartomas are rare tumors. They frequently contain areas of calcification and thus resemble inflammatory nodules rather than carcinoma. Solitary fluid filled cysts also are rare lesions except in or close to the mediastinum. Tumors of the ribs should be diagnosed correctly after thorough roentgen study. Solitary metastatic nodules are moderately frequent. In practically all cases the primary tumor is known at the time the pulmonary lesion is found or can be discovered by a reasonably thorough search. In most of our cases the nodule was discovered during a routine search for possible metastases from a known primary tumor.

7. *Miscellaneous*—The fifteen tumors included in this group were lesions which did not fit into any of the previous categories. In one case there was only evidence of obstructive emphysema. In others a combination of findings was present such as fluid and abscess formation, broncho-pleural fistula, metastases to other parts of the lung, etc.

Summary and Conclusions

An analysis of the roentgen changes in 148 proved cases of bronchogenic carcinoma is presented. Males predominated over females in the ratio of 9 to 1. The average age of the patients was 56.1 years. The majority of the tumors, 74, were squamous cell carcinomas. The difficulties in differential diagnosis of small peripheral mass shadows are mentioned particularly when the lesion is found incidentally on routine examination of the chest.

Wisconsin General Hospital.

Common Errors in the Diagnosis of Carcinoma of the Lung

By C. L. HOLMES, M. D.
Marshfield

CARCINOMA of the lung now exceeds[1-5] carcinoma of the stomach as the most frequent cancer in males. The reason for this striking increase in incidence is not known. Cigarette smoking[5] and exposure to certain chemical irritants are believed to be important factors. Improved diagnostic technics account for only a part of it. Furthermore, the experience of workers in diseases of the chest is that, in spite of modern advances in diagnostic methods, the individual patient in many instances is not given the benefit of early diagnosis. Far too many patients are neglected during the early stages when definite cure can be accomplished.

The diagnosis of carcinoma of the lung is not difficult and can be made with accuracy by observing two principles: first, thinking of the disease; second, making use of all diagnostic aids. The case reports and discussions which follow illustrate the importance of strict adherence to these principles and the consequences of deviation therefrom.

The patient's history, always important in medical diagnosis, is chiefly of value in localizing the pathological process. There is no classic story diagnostic of cancer of the lung, and conversely there are no histories which permit us to eliminate cancer from the diagnostic possibilities. Cough, expectoration, fever, pain in the chest, and hemoptysis suggest its presence, but by the time the patient has these symptoms the opportunity for curing him usually is passed. Herein lies the reason survival rates are so poor.

A careful physical examination not only may disclose pulmonary pathology, but also may detect axillary or supraclavicular masses, biopsy of which can establish the diagnosis and tell us immediately if we are dealing with inoperable carcinoma of the lung.

The history and physical examination, important in the preliminary survey of the patient with pulmonary symptoms, must be regarded in the light of their limitations. We accept the stethoscope as an old and valued friend in physical diagnosis but must not rely on it to rule out serious disease in the chest. Never must the findings elicited by auscultation be the basis of a definitive diagnosis, such as "pneumonia," "pneumonitis," or "bronchitis." From the physical examination we must go on to the more exact diagnostic procedures.

Routine laboratory tests, useful in evaluating the general condition of the patient, add little to our knowledge of the specific lesion we are attempting to identify. However, study of the sputum for tubercle bacilli and the type of predominant organism must not be neglected.

Cytologic studies, using the methods of Papanicalaou, aid greatly in the preoperative diagnosis, particularly in upper lobe lesions not accessible to the bronchoscope. Material aspirated through the bronchoscope permits a higher percentage of positive results than does sputum expectorated by the patient. However, we must be constantly reminded that a negative smear from bronchial aspiration does not rule out cancer. Furthermore, to keep repeating these negative studies over and over causes a serious loss of time.

Therapeutic trials with antibiotics for undiagnosed, presumably inflammatory lesions, is one of the most common mistakes in clinical medicine. Especially misleading is the temporary improvement frequently seen in patients with lung cancer whose clinical manifestations are ushered in by an infectious episode. Even more fallacious, when a process fails to respond to a particular antibiotic, is the practice of wasting further time with sensitivity tests. Instead of proceeding directly with measures to establish a definite diagnosis, the erring clinician tries one antibiotic after another, attributing the lack of response to wrong choice of medicine rather than to wrong diagnosis.

All of us who are working for improvement in the survival rates in cancer of the lung plead earnestly for the routine use of chest roentgenograms in all physical examinations, and we look forward with hope to the time when mass screening of the population will be possible every two years. The full benefit of such a program will not be realized, however, unless proper follow-up is instituted in all patients with abnormal findings. The physician must insist that his patient submit himself for complete study. This must include exploratory thoracotomy if a diagnosis cannot be made otherwise in a short time. A common mistake is to keep repeating x-ray studies, looking for positive diagnostic signs, thus losing valuable time and robbing the patient of his chance for cure. Failure to take chest x-rays and failure to follow up abnormal findings with conclusive diagnostic tactics are common errors.

The bronchoscopic examination is the next step towards cure of early lung cancer and failure to make this examination has had tragic results too often. Besides providing uncontaminated bronchial secretions for routine cytologic study, bronchoscopy permits visualization of the primary and most of the secondary bronchioles, where 95 per cent of cancer of the lung originates. The thoracic surgeon should make the examination himself or at least be present for it, because when cancer is found he can then locate the upper extent of the growth and can look for tracheal invasion, cord fixation, widen-

*From the Department of Surgery, Marshfield Clinic and St. Joseph's Hospital.

ing of the carina, and other signs that indicate whether or not the lesion is resectable.

Another source of clinical error is the misuse of Lipiodol. While this material is of invaluable help in the study of the patient with bronchiectasis, it rarely has a place in the diagnosis of cancer of the lung. It adds nothing to the information already obtained by x-ray and bronchoscopy. Since it may seriously obscure the involved area and interfere with subsequent examinations, its use should be limited to the rare occasion where certain portions of the bronchial tree need to be visualized by contrast media.

Perhaps the most common cause for error is the acceptance of a ready made diagnosis for the patient's chest symptoms, thus prolonging treatment and delaying definitive diagnostic studies. The diagnosis "virus pneumonia" should be made with reservation, and with the realization that the process may be covering up a carcinoma that will certainly cause the patient's death if surgical treatment is not instituted before metastasis occurs. Without doubt pneumonia sometimes does become "unresolved" and it may even be "atypical," but to continue to treat the patient month after month only to learn, after careful diagnostic work is finally resorted to, that the patient now has an inoperable carcinoma of the lung, is one of the principal reasons for our slow progress in combating this disease.

Since carcinoma of the lung manifests itself in many different ways, it is, like syphilis, a great imitator, and must be included in the differential diagnosis of all chest symptoms. Because it may produce lesions indistinguishable from tuberculosis, the mistake is made of sidetracking the search for cancer in order to settle first the question of tuberculosis. Time runs out all too soon for the cancer patient, and it should not be wasted in attempts to culture tubercle bacilli from the various secretions of the body. Our first responsibility to the patient is to confirm or exclude cancer. Even in the presence of a possible tuberculous focus, the health interests of the patient are better served if we resect the area than if we continue trying to prove its tuberculous nature by other means over too long a period.

In the six case reports which follow a number of the diagnostic principles and errors we have just discussed will be illustrated. In addition to illuminating these points the reports exemplify three of the main forms in which the growths appear clinically, namely, (1) tumor, (2) consolidation, and (3) abscess. The first two patients had neoplasms that manifested themselves as tumors on the x-ray, the next two as areas of consolidation, and the last two as abscesses.

Case Reports

CASE 1—T. H., age 67, was seen July 28, 1950, by an internist because of nervousness. A complete examination, including neurological, was normal. His history suggested the presence of duodenal ulcer. He was scheduled for a chest x-ray and gastrointestinal series the following day. However, that evening because he failed to recognize friends he was admitted to the hospital and generalized convulsions began shortly afterwards. The next morning his sensorium was clear, and an ulcer of the duodenum was demonstrated by x-ray. Antero-posterior x-rays of the chest (Fig. 1a) were reported as showing an "unusually prominent hilus." However, closer inspection of the films revealed a spherical mass near the superior aspect of the hilus. On the lateral view (Fig. 1b) the hilar mass was seen more definitely. A marked narrowing of the right main stem bronchus was seen through the bronchoscope just above the level of the middle lobe orifice as if an extrinsic mass posterior to the bronchus were bulging the membranous position. By means of a biopsy, which showed a small cell carcinoma, the

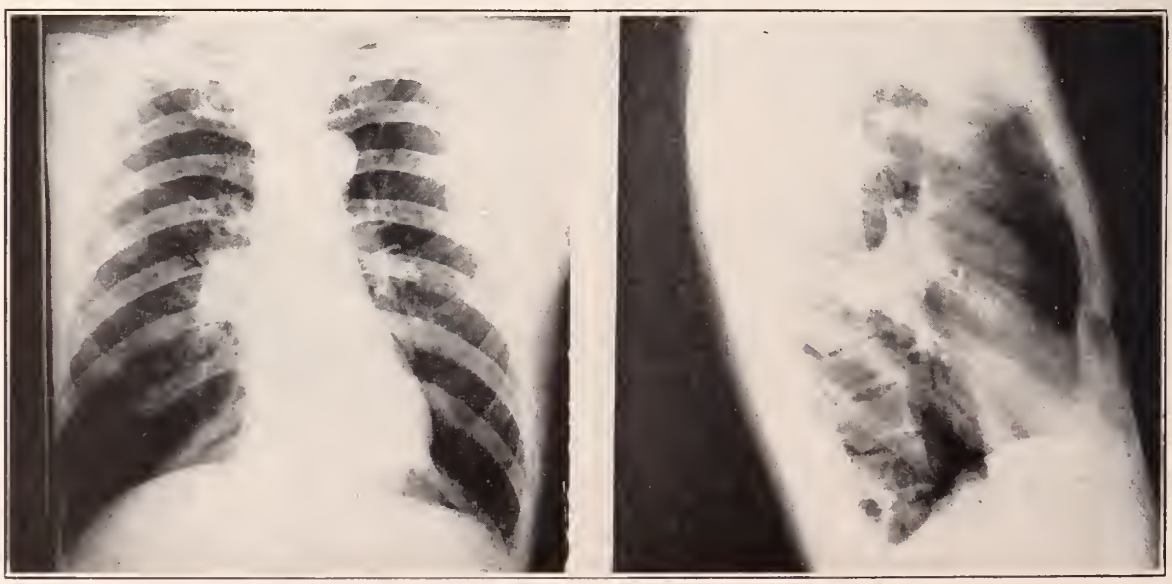

Fig. 1a Fig. 1b

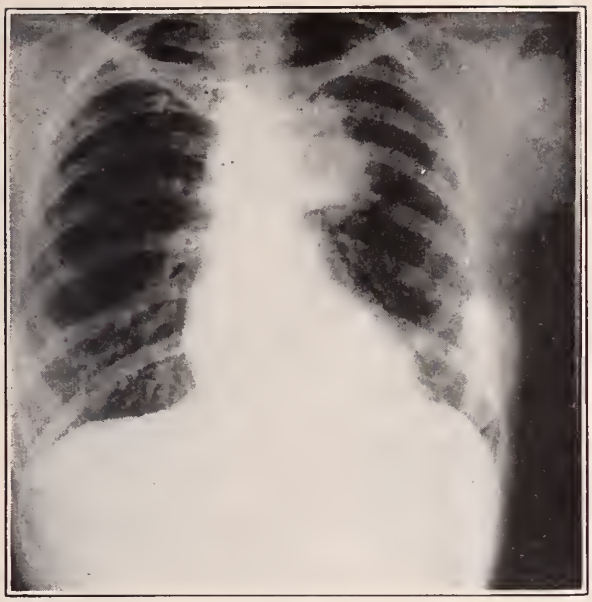

Fig. 2a

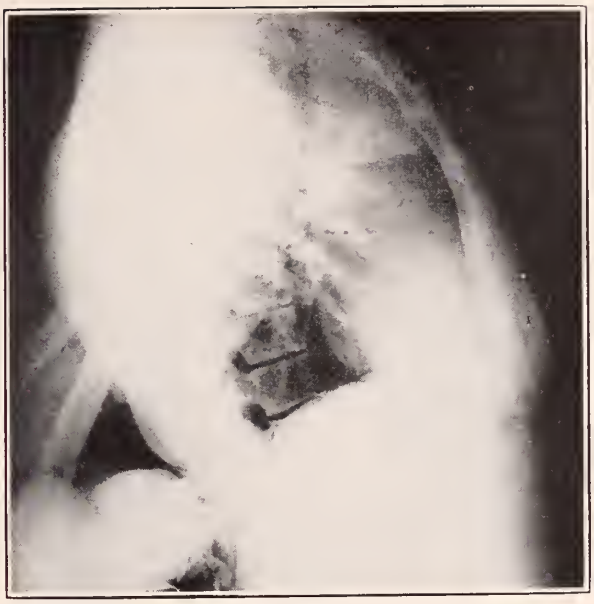

Fig. 2b

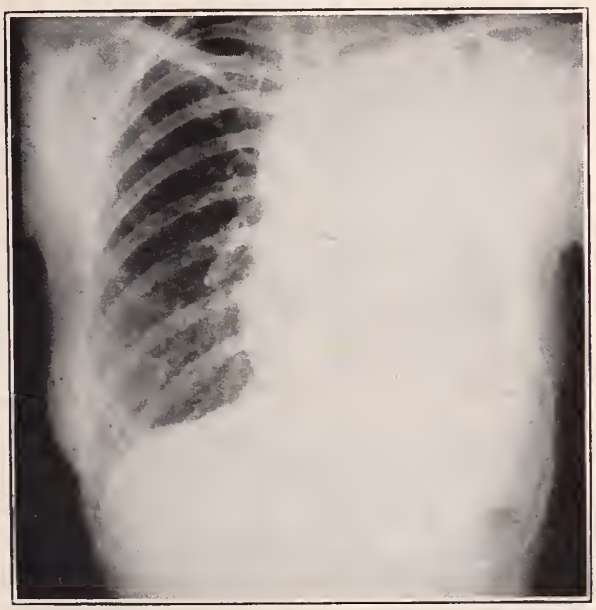

Fig. 2c

diagnosis of carcinoma of the lung with cerebral metastases was made. The patient rapidly declined and died two months later. Autopsy further confirmed the diagnosis.

Comment: This illustrates an asymptomatic carcinoma of the lung which became known because of its cerebral extension. Approximately 30 per cent of cerebral neoplasms are metastatic from elsewhere. The primary lesion could easily have been overlooked if an unusually careful scrutiny of the x-ray had not been made and the lateral view taken. All patients with "unusually prominent" hilar shadows should have films taken in the lateral position and a bronchoscopic examination made if any doubt remains about the diagnosis.

CASE 2—E. T., a 35 year old white female, was treated by her local physician in September 1949 for "flu." She was advised to have an x-ray of her chest made but postponed it until March 1950. At this time, she had no cough, expectoration, hemoptysis, weight loss, or fever. Her only complaint was pain in her left anterior chest on lying down. By x-ray examination (Fig. 2a) a large mass was seen in the left hilar region. On the lateral view (Fig. 2b) an anterior segmental atelectasis was demonstrated. Bronchoscopy failed to reveal a bronchial lesion. Several specimens of bronchial secretion were examined but contained no cells suspicious of carcinoma. The original diagnosis was lymphoblastoma of the mediastinum, and a course of x-ray treatment was planned. But because of the patient's age, somewhat bizarre history, and negative bronchial studies, carcinoma was considered the more likely diagnosis, and upon further consultation with the radiologist and the internist, an exploratory thoracotomy was carried out.

A small primary neoplasm was found deep in the fissure between the upper and lower lobes, arising from the anterior segmental bronchus with an adjacent area of atelectasis. The large mass seen in the x-ray film was a large metastatic mass within the mediastinum. Thereafter pneumonectomy was carried out (Fig. 2c) and the mediastinum dissected as completely as possible and the metastases removed. A course of deep x-ray therapy was given over the mediastinum posteriorly. The patient died in January 1952 of spinal metastases, having lived almost two years without serious complaint until three months before her death.

Comment: In the first two patients (cases 1 and 2), the clinical features were those of tumor formation. In case 2 the mass consisted of metastases in the mediastinum. This case report illustrates the consequences of failure to take a routine chest x-ray

Fig. 3a

Fig. 3b

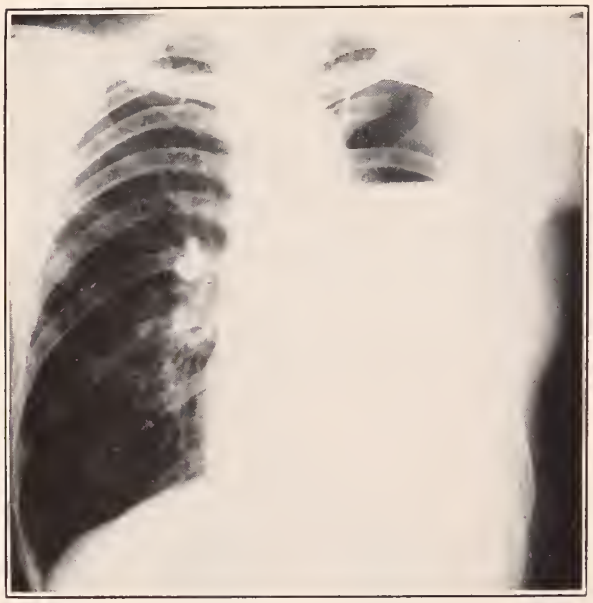

Fig. 3c

and the importance of exploratory operation when a definitive diagnosis cannot be quickly established.

Case 3—C. R., a 52 year old white male, was admitted to the hospital February 19, 1950, as a cardiac emergency. He was seen in his physician's "atypical pneumonitis." (Fig. 3a) Antibiotic therapy office because of severe pain in his left chest, shoulder, and arm. Cyanosis was noted. An electrocardiogram was normal, but the chest x-ray revealed an effected some improvement and eight days later a second film was taken. (Fig. 3b) With subsidence of the infectious process a tumor was made apparent in the left hilar region. No ulcerative lesion, inflammatory or neoplastic, was found at the bronchoscopic examination. Cytologic study of the bronchial secretions was negative. Nevertheless, exploratory thoracotomy was recommended and was carried out February 27, 1950. A tumor 6 cm. in diameter was found at the hilus within the upper lobe. No hilar metastases or mediastinal glands containing metastatic deposits were found. A left total pneumonectomy (Fig. 3 c) was performed, and the patient was discharged after ten days. The patient was alive and well in September 1952.

Comment: This case report shows the difficulty of visualizing upper lobe lesions and of obtaining biopsy material from them. It illustrates also how a pneumonic process can completely overshadow a tumor and that, in spite of a favorable clinical course, diagnostic studies must be pursued and exploratory operation resorted to, if necessary, to identify positively atypical pulmonary lesions. It is in these "unresolved," "atypical," and "virus" pneumonias that delay is likely to occur in the recognition of an underlying cancer.

Case 4—A. B., a 48 year old white male, was seen by his physician in August 1949, because of severe cough, expectoration, chest pain, fever, and loss of weight. He stated that he had had a cough for 20 years, attributed it to cigarettes, and that it had been worse for the past three months. A questionable mass in the hilus was seen on x-ray films (Fig. 4a, 4b), and there was definite evidence of consolidation of the middle and lower lobes. An obstructing lesion was found by bronchoscopic examination at the level of the middle lobe orifice, and biopsy proved the presence of undifferentiated cell carcinoma. The vocal cords moved normally and the carina was not significantly widened. In the absence of definite signs of inoperability, an exploratory operation was carried out. Complete consolidation of the middle and lower lobes was found distal to the large hilar mass. The mediastinum, paratracheal nodes, and pericardium were extensively involved.

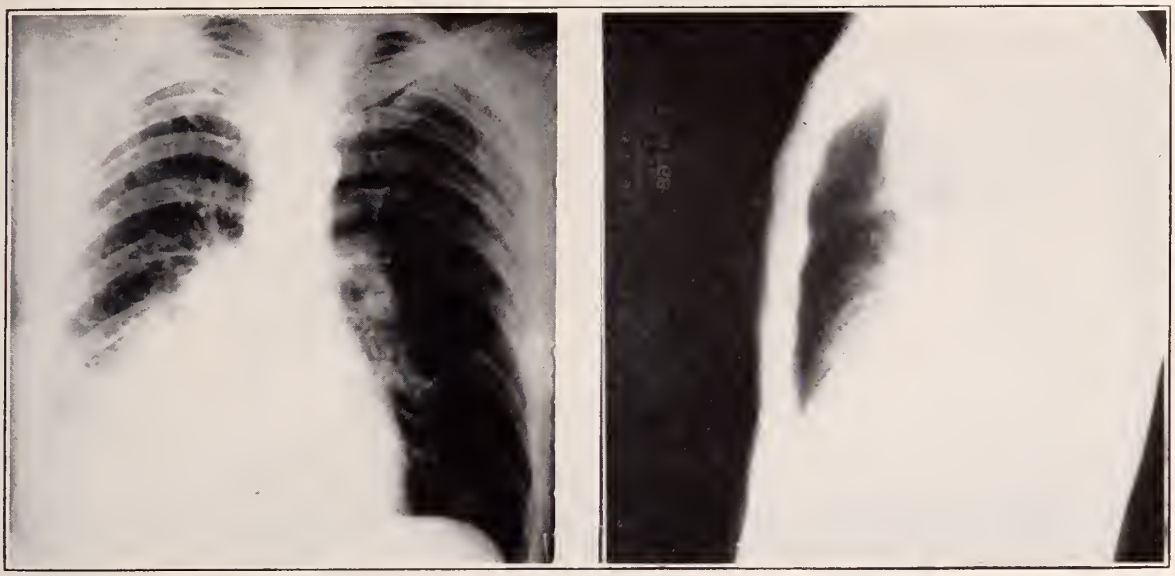

Fig. 4a

Fig. 4b

The chest was closed. Postoperative deep radiation was given, but the patient died eight weeks later.

Comment: Diagnosis was delayed because the patient had a chronic cough for which he had a ready-made explanation. Routine x-ray at an earlier date could have demonstrated pulmonary pathology in time for a cure.

Case 5—R. W., age 81, was referred by an internest for bronchoscopy after an x-ray revealed a lung abscess. (Fig. 5a, 5b) He was extremely debilitated and obviously beyond much help. A large abscess of the left lower lobe was found by bronchoscopy and just proximal to this abscess cavity was a large neoplastic ulcerated lesion which microscopic examination showed was a small undifferentiated cell carcinoma. The patient died one week later, apparently from coronary occlusion. Postmortem examination was not made.

Comment: This patient's lung abscess was of neoplastic origin. His experience illustrates how the diagnosis of lung cancer can be obscured by an infectious process.

Case 6—J. M., a 52 year old white male, was first ill with "influenza" in November 1949. His physician gave him penicillin and some other "shots." Improvement was not satisfactory, and he was advised to have bronchoscopy, but nothing further was done until March 1950, when, still coughing, he was examined by another physician and x-rays were taken. An abscess of the lower lobe was found and at bronchoscopy an obstructing neoplasm was seen just distal to the orifice of the left upper lobe.

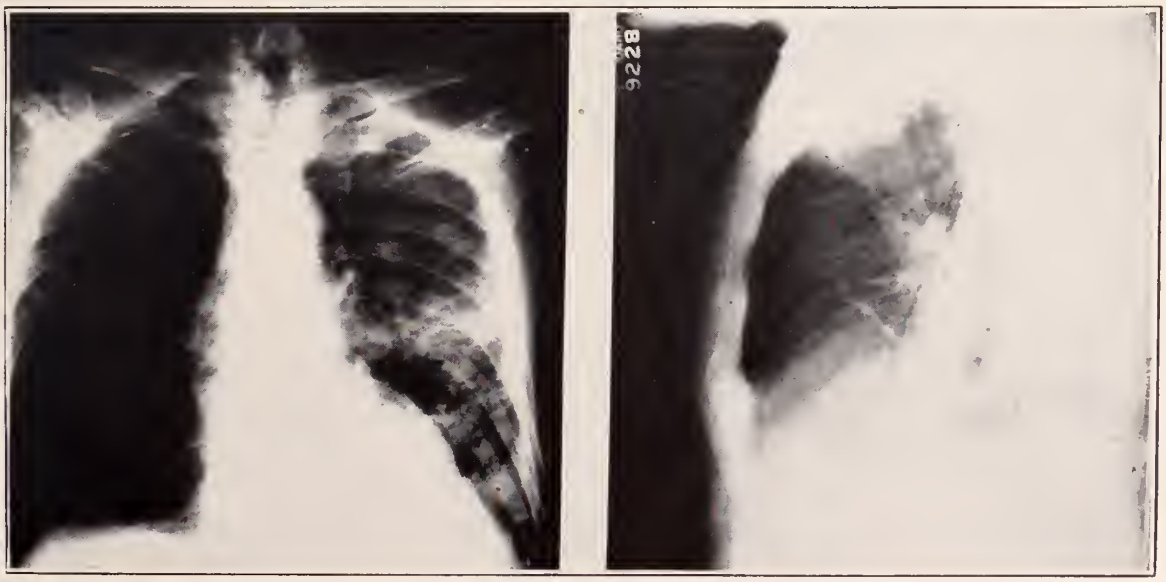

Fig. 5a

Fig. 5b

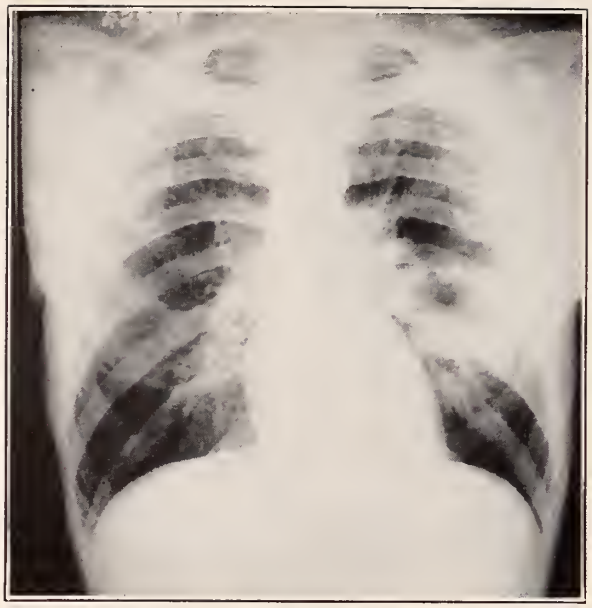

Fig. 6a

Fig. 6b

Fig. 6c

Biopsy revealed it to be a squamous cell carcinoma. A left pneumonectomy was performed. Two hilar glands were involved by carcinoma, but none of the mediastinal glands was involved. The patient recovered without complications and remains well to the present time, despite the unnecessary delay of five months in making the correct diagnosis.

Comment: Cancer can produce lung abscess in two ways, either by the breakdown of an infected atelectatic area produced by the bronchial obstruction, or by central necrosis and liquefaction of the cancer itself. About one-fourth of all pulmonary carcinomas are associated with abscess formation.

Summary

In this consideration of cancer of the lung we have discussed the common errors in diagnosis that cause delay in treatment and make poor survival rates. Six cases are reported illustrating the important diagnostic principles. These are as follows:

(1) Keep acutely aware of its possibility in all cases of pulmonary pathology.

(2) Act promptly in determining the facts by all of the necessary diagnostic procedures.

(3) Take routine x-rays wherever possible, including lateral or other special projections when abnormalities appear.

(4) Make bronchoscopic examinations early.

(5) Study bronchial secretions for malignant cells, remembering always that a negative study does not rule out cancer.

(6) Resort to exploratory operation when these studies do not result in a diagnosis.

(7) Take effective diagnostic action early, avoiding the delay involved in weeks of "expectant," symptomatic treatment or therapy based on the presumption the inflammatory factor is the only one.

Marshfield Clinic.

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THE MEDICAL FORUM

DOCTORS SPONSOR TURK STUDENT IN UNIQUE PR MOVE

B-K-D-SOCIETY SPONSORS STUDENT—A Turkish student who wants to become a doctor is being sponsored in a Green Bay High School by the Brown-Kewaunee-Door Medical Society. Green Bay physicians have taken Can Epirden, center, of Istanbul under their wing for the school year. He is shown above with Dr. Gerald B. Merline, vice president of the medical society, left, and Dr. John L. Ford, president, right.

Green Bay, Oct. 21.—The Brown-Kewaunee-Door Medical Society is sponsoring the exchange education of a young Turkish student at Green Bay as part of its expanding public relations program.

The student is 16 year old Can (pronounced John) Epirden, son of the vice-president of the Guaranty Bank in Istanbul. Young Epirden wants to become a doctor, but is now attending Green Bay East High School as a senior under sponsorship of the county medical society. He is the sixth foreign student to enroll in a Green Bay public school this year in cooperation with the American Field Service.

Dr. John L. Ford, Green Bay, president of the county medical society, points out that its sponsorship of the Turkish student is part of a program to establish good public relations on local and county levels.

Other steps taken in this direction, according to Dr. Ford, have been conferences with nurses, druggists, newspapers and radio stations. Members have also volunteered their services in various civic activities, including the examination and immunization of children, civilian defense, and medical supervision of the Red Cross blood donor program in the counties.

Dr. Ford said that Mr. Epirden will attend meetings of the county medical society and will be taken on a tour of local hospitals and health facilities by members of the society. He will also visit the offices and homes of some of the local doctors so "that he may become better acquainted with our American way of life."

"It is the hope of the medical men of this community that Can Epirden and his fellow visiting students eventually may be a potent factor in the promotion of harmony, understanding and peace with all nations," Dr. Ford said. After he leaves the United States Mr. Epirden believes he will enroll in a medical school, probably one outside his homeland of Turkey.

2 M.D.'s Named to Nurse Education Study

Madison, Oct. 28.—Dr. A. H. Heidner, West Bend, and Dr. Weston Gardner, Milwaukee, have been selected to serve on an advisory committee to develop a state-wide plan for nursing education.

The appointments were announced by Adele G. Stahl, R. N., secretary of the Wisconsin State Board of Nursing after a meeting in early October.

Shortage Studied

The advisory committee will study the nursing shortage, determine where the greatest needs exist, establish plans for the recruitment of nurses and make suggestions for increasing the output of nurses in the various nursing educational institutions in Wisconsin. Its recommendations will be made to the State Legislature.

Don't Miss Public Relations Event of the Year

Physicians who guide public relations programs of state and county medical societies should attend the AMA's 1952 Medical Public Relations Conference at Denver, Colorado, December 1.

The conference is to be held at the Shirley-Savoy Hotel a day before the AMA's mid-year session.

Panel discussions on press-radio codes, methods of explaining the cost of sickness to patients, itemizing medical bills, and how to set up county public relations programs will be held starting at 10 a.m., December 1.

Watch the November 22, 1952 issue of the AMA Journal for more details. Plan now to attend.

HEALTH INSURANCE ARGUED BEFORE TRUMAN COMMISSION

Washington, D. C., Oct. 14.—Problems of financing medical care, with emphasis on the issue of national *compulsory health insurance*, were argued last week before the President's Commission on the Health Needs of the Nation.

Panel participants in the two-day sessions (Oct. 7–8) included several spokesmen long associated with the Truman–Ewing plan. Opposing their views were representatives of American Medical Association, non-profit and commercial health insurance organizations, hospitals, industry and the U. S. Chamber of Commerce.

There was agreement among participants on a number of points, particularly:

a. that the country has an unprecedented health record for the last half century.

b. that the various types of voluntary health insurance have experienced a phenomenal growth in public acceptance.

c. that better medical care should be extended to the undetermined number of people who are not now being cared for adequately.

Commission Disagrees

But the discussion ended with continued disagreement on:

a. exact or even relative number of Americans not adequately protected, by prepaid insurance or otherwise,

b. ability of the voluntary plans to expand rapidly enough, qualitatively and quantitatively, to meet the need,

c. whether national compulsory health insurance is the answer.

Spokesmen for the non-profit plans insisted throughout that they would be able to supply any coverage the public needs. They said federal and state governments should cooperate by permitting Blue Cross and Blue Shield payroll deductions for their employees and by extending unemployment compensation to include payment of insurance premiums.

It was also proposed that federal or state governments subsidize premiums for low income groups, possibly through a system similar to the Hill–Burton program.

Following are brief quotations from some participants, as reported by the Washington office of the A.M.A.:

Frank G. Dickinson, Ph.D., Director of the Bureau of Medical Economic Research, American Medical Association: "It would take just 54% of a week's wages in 1951 to purchase the same amount of medical care as a whole week's wages would have purchased in 1935–39"—Medical care costs as a whole are lagging well behind prices in general—All statistics show remarkable improvement in maternal and infant mortality rates and startlingly longer life expectancy.

"We Will Close Gaps"

Harry Becker, Associate Director, Commission on Financing of Hospital Care and former Social Security Director for CIO: "If we accept the pattern of financing which establishes voluntary prepayment for the families of the currently employed and which, through government assistance, provides the same standard of care on essentially the same basis for non-wage and low income groups—we will close most of the existing gaps in financing care. . . ."

William S. McNary, Executive Vice President and General Manager, Michigan Hospital Service: "Health service . . . is bringing into Blue Cross thought an increasing understanding of the importance of maintaining a balance between local or regional needs and the demands of the national economy. Where definite inadequacies exist, Health Service can step in and build up the benefits to the required uniform national levels. Thus—Blue Cross is raising national standards without imposing the hobbles of centralization."

Dr. Charles G. Hayden, executive Director, Massachusetts Medical Service: "Basically this (OASI) is a simple cash transaction and the recipient can do what he pleases with the money. Under federal compulsory health insurance, however, the federal government also proposes to collect the money, but instead of returning money to patients requiring medical care, it would undertake to provide the personal services of physicians. How this could be done without imposing controls on the medical profession I, as the administrator of a medical care plan, cannot understand. . ."

Extras Deter Families

Dr. George Baehr, President and Medical Director, Health Insurance Plan of Greater New York: "The many extra charges that doctors are permitted to make under the limited plans deter families from availing themselves of the benefits of preventive medical services and Voluntary insurance will not be accepted as the final answer . . . until it can provide comprehensive coverage to those who want it and should have it. . ."

I. S. Falk, Ph.D., Director, the Division of Research and Statistics, Social Security Administration, FSA.: "Voluntary insurance plans . . . hinder at least as much as help the development of group practice required for advancement of quality of care. . . If we agree on the need for wider use of insurance. . . we find that voluntary insurance does not and cannot meet our needs . . ."

Dr. Vlado Getting, Commissioner, Massachusetts Department of Health: The Commission has been spending too much time on how to finance medical care and not thinking enough about how to reduce the risks of poor health. . . The greatest need is nation-wide development of full-time local health departments.

PUBLIC RELATIONS TIP FOR NOVEMBER

Has the film, "Your Doctor" a short produced by RKO-Radio with A.M.A. assistance, been shown at your local movie houses?

If not, contact your local movie theatre manager or ask the state medical society to contact him and urge him to book this film.

The picture shows how a man gets to be an M.D., how he practices, keeps pace with medical progress, contributes to public health and betterment. It has been enthusiastically received by audiences wherever it has been shown.

Harold M. Groves, Professor of Economics, University of Wisconsin: ". . . the case for federal aid to medical education is strong and convincing. . . . It should be our objective to devise a scheme of compulsory insurance . . . perhaps by a 2% income tax for compensation of catastrophic illness."

Michael M. Davis, Ph.D., Chairman, Committee for the Nation's Health: "For most of the American people, health insurance should be required by national law. . . . Without a broad and positive national program, I anticipate a mixture of commercial and non-profit voluntary insurance which will be quantitatively insufficient and often qualitatively poor, plus the piecemeal but steady growth of directly tax-supported medical and hospital care. . ."

E. A. Van Steenwyk, Executive Director, Associated Hospital Service of Phila.: Solution of the problem of meeting the public's bill for medical care of the poor will require participation of government at all levels. Federal grants along lines of the Hill-Burton hospital program to state medical authorities for paying costs for the medically indigent should be tried.

Nelson H. Cruikshank, Director, Social Insurance Activities, AFL, and Labor Advisor to Mutual Security Agency: "Organized labor and all wage earners are united in demanding a system of national health insurance for the benefit of all. . . . Labor has tested the voluntary plans and with few exceptions has found them seriously wanting."

The Commission reached no conclusions on the issues involved. It met in executive session on October 9 and will hold another three-day closed meeting later this month. Its report to the President is due by December 29.

NEW BOOK ON HEALTH RESOURCES

Chicago, Oct. 14.—The Brookings Institution in Washington has just announced publication of a new book, "Health Resources in the United States," which gives a factual account of the personnel facilities, and services available to serve the nation's health.

More Federal Funds Urged for Care of Aged Ill

Washington, D. C., Oct. 15.—Greater use of federal funds was recommended in several fields at recent open hearings of the President's Commission on the Health Needs of the Nation.

Lay and medical witnesses repeatedly stressed the need for more funds, more services and more facilities. Recommendations made by the panel members of the Commission to the Commission itself included:

1. Rural health—A method "must be found" to finance medical education for rural youths and to provide internships and proctorships in rural settings in order to develop general practitioners for rural areas.

Funds For Aged

2. Health of the aging—Economic status of most older people is such that "adequate medical care can be provided them only through substantial use of public funds."

3. Care of the chronically ill—In spite of savings from concentration on prevention, detection, control and rehabilitation, "it is probable that even larger sums, public and private, will be needed before care of chronic illness is comparable . . . to that given acute illness."

4. Mental health—More psychiatric training of medical students; health groups such as Blue Cross should extend their coverage to include mental disorders.

Doctors Now Have 15 Days to Notify VA in All Vet Cases

Madison, Oct. 28.—Veterans Administration has announced the extension of the notification period for emergency or prompt treatment of Spanish American veterans from 24 hours to 15 days. This ruling has the effect of making the notification period uniform for all veterans.

Public Law 791, 81st Congress, passed in September of 1950, empowered the VA to furnish outpatient treatment to veterans of the Spanish American War, for any and all conditions. For all other veterans out-patient treatment may be provided only for conditions which are determined by the VA to have been incurred or aggravated in service.

Originally, VA interpreted the Spanish American law so as to restrict treatment except when an application therefore had been received and the doctor authorized to treat prior to the actual treatment. Later a 24 hour notification period was allowed, permitting authorization of emergency or prompt treatment if VA was notified within one day of such treatment.

Now physicians have the same notification period, 15 days, in Spanish American cases as has always been granted for obtaining authority to treat service connected conditions.

CLAIM BLANKS

A Wisconsin doctor is likely to handle more TIME claim blanks than any other company's. TIME, a leader in the accident and health insurance field, insures a large portion of the total number of persons carrying such insurance in Wisconsin.

Few doctors appreciate the great service given to their patients when these claim forms are handled promptly.

Any suggestions from you as to how our claim forms may be improved will certainly be appreciated.

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Dr. Griffith Named Chairman of Student Loan Fund; A. M. Werner Is Vice-Chairman

Madison, Oct. 28.—Dr. J. C. Griffith, Milwaukee, president of the state medical society was named chairman of the Student Loan Fund of the state society at a recent meeting.

Other officers elected were A. Matt Werner, Sheboygan, vice-chairman and C. H. Crownhart, Madison, secretary-treasurer.

Dr. I. R. Sisk, Madison, was elected to a second term as a member of the Board of Trustees.

Other members of the board are: Dr. H. K. Tenney, Jr., Madison; Dr. R. G. Arveson, Frederic; and the Honorable Oscar Rennebohm, Madison.

To date, 45 contributors have given a total of $10,660 to the fund.

On October 7, the society was ordered to conduct a personalized mail and direct contact campaign among all the physicians in Wisconsin. It is hoped that this solicitation campaign will raise the student loan fund well toward its goal of $250,000. Following the campaign among the physicians, it is expected that the society will seek contributions from business, industry, labor and agriculture.

County Society Has Novel Health Column

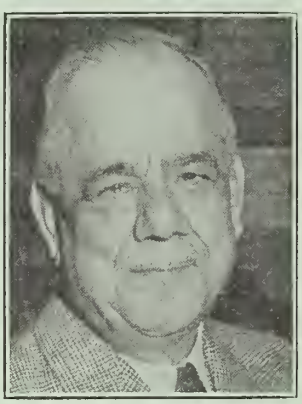
Indianapolis, Sept. 24.—A novel publicity feature has been initiated by the Indianapolis Medical Society with the help of the Indianapolis News.

Each Saturday the newspaper is publishing a health column on its front page. It is entitled "My Doctor" and is prepared by the medical society's public relations committee.

Questions are submitted by readers and answered by the local medical society.

The column always closes with this paragraph:

"If you have a health question, send it to "My Doctor," Indianapolis News. For your health's sake, consult your neighborhood physician. If you have no family doctor, the Indianapolis Medical Society, Franklin 2453, will provide the names of reputable physicians in your neighborhood."



A. M. WERNER

Dufour Is Appointed Executive Secretary of General Practice Academy

Milwaukee, Aug. 11.—Mr. Robert Dufour, Milwaukee, has been named the executive secretary of the Wisconsin Academy of General Practice, according to Dr. Robert Purtell, Milwaukee Society secretary.

Mr. Dufour has a background of writing and free-lance advertising and is currently engaged in postgraduate work at Marquette University School of Journalism.

Madison Student Does Survey for AMA

Chicago, Aug. 1.—A Madison, Wisconsin, medical student at Northwestern University Medical School has been employed by the American Medical Association to assist in several studies on medical service.

He and another Northwestern medical student will work on two major projects under direction of the Council on Medical Service:

1. **Development of criteria for evaluating a community's need for a physician or additional physicians and for evaluating the characteristics of a community which tend to attract physicians.**
2. **Appraisal of union health plans. This will involve personal visits with several plans to obtain detailed information on the objectives, scope, facilities, and personnel involved in such plans, together with the arrangements that have been made between the plans and the medical profession.**

Both students will also participate in a continuing study of indigent medical care plans in the midwest. The Madison and Dane County medical plans for caring for the indigent were examined last year.

Wisconsin Man to Aid in National Illness Survey

Madison, Aug. 11.—Prof. Edwin E. Witte, chairman of the Department of Economics of the University of Wisconsin, and Frank Dickinson, Ph.D., director of the Bureau of Medical Economic Research of the American Medical Association, are among the 18 experts who have accepted appointments to advise the Research Council for Economic Security in a nation-wide survey of the economic aspects of prolonged nonoccupational illness among employed persons.

The two-year study will involve more than 400,000 employees and will try to find out how extensive the problem of prolonged nonoccupational illness is in private industries throughout the country.

Absences due to illness of any duration are being recorded, and the relationship of the incidence and duration of these illnesses will be analyzed as they relate to income groups, occupation, age, sex, medical facilities available and types of employee benefit plans available.

Hospital Planners Elect Otis President

Madison, Sept. 22.—Vincent F. Otis, director of the division of hospitals and related services of the Wisconsin state board of health, was elected president of the Association of Hospital Planning Agencies at the group's fourth annual meeting in Philadelphia recently.

Association members represent agencies responsible for hospital surveying, planning, construction, and licensing in each of the 48 states.

Expect 6,500 Medical Graduates Next Year; Enrollment Going Up

Chicago, Sept. 12—Facilities for medical education in the United States are at an all time high.

There has been an unprecedented increase in teaching facilities since the end of World War II and medical schools are now receiving better financial support that at any other time in their history, according to the 52nd annual report on medical education in the United States and Canada made by the Council on Medical Education and Hospitals of the American Medical Association.

There were 27,000 medical students enrolled in the United States schools in 1951–52, as compared with 26,000 in the preceding year.

Last year's freshman class numbered 7,440 students, or 3.6% more than the prior year.

There were 6,080 students graduated this year, a record number for a regular schedule. The total was surpassed only in 1947, when several schools graduated more than one class with war time accelerated programs, and in 1951 when one school graduated an extra class making that years total 6,135.

An estimated 6,500 students will graduate next year.

Millions Spent

More than $300,000,000 has been spent in expansion of medical school facilities since the end of the last war the report stated.

In addition there are 13 projects now in various stages of development that are aimed at founding new schools or expanding some of the two year basic science schools to four year schools.

Total fund for operating the schools, including research, increased in the past year from $109,000,000 to $120,000,000. The increased investment in medical education has come about largely through increased legislative appropriation, federal grants and aid, gifts for endowment and current expenses, alumni funds, and more recently, the efforts of the National Fund for Medical Education and American Education Foundation.

Although it was pointed out that some schools still have a tremendous lack of funds for adequate operations, the report stated that "medical education is better supported today than at any time in its history."

W. H. SOUTHWORTH

Southworth to Help Build Up Medical Teams for Civil Defense

Madison, Oct. 1.—Recognizing the importance of educational leadership in the State Civil Defense program, the University of Wisconsin has assigned Prof. Warren H. Southworth of the school of education, to the office of the state civil defense director.

He will serve as medical team coordinator in civil defense until February, 1953.

This action was taken at the request of General Ralph Olson, state civil defense director, and with the approval of Governor Kohler, and the University Board of Regents.

The more than 100 mobile medical units that have been organized throughout the state are considered one of the most vital parts of the entire program for civil defense. Each one includes a total of 29 persons—physicians, dentists, nurses, stretcher bearers, first aiders, business manager and radiological monitors.

As medical team coordinator, Prof. Southworth will develop an up-to-date roster of the medical teams, complete a manual of operation for the teams, and participate in the training program for the teams.

Prof. Southworth, who holds a Doctor of Public Health degree, has long had a close working relationship with Wisconsin physicians through the State Board of Health and the State Medical Society.

2 District Health Officers Appointed

Madison, Sept. 15.—Two physicians have been named to district health officer posts as a result of recent State Board of Health action.

Dr. John Allen, Madison, was appointed to fill the post in the district office at Madison. Doctor Allen was graduated from the University of Wisconsin School of Medicine in 1951.

Dr. James R. Slamer, Milwaukee, will assume the duties of Dr. Donald Engles, who resigned June 11 as district No. 3 health officer in Fond du Lac.

The new health officer will begin formal training at the University of Michigan, Ann Arbor, late in September and start work in Fond du Lac in June, 1953. A 1950 graduate of Marquette university school of medicine, Doctor Slamer is the youngest district health officer in the state.

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300 ATTEND CONFERENCE ON PHYSICIANS AND SCHOOLS

Madison, Oct. 18.—The improvement in the health of school children during the last few decades has been truly phenomenal, Dr. George M. Wheatley, third vice president of the Metropolitan Life Insurance Company of New York told the Wisconsin Conference on Physicians and Schools at its mid-conference dinner session.

Doctor Wheatley said that the diseases associated with middle and old age are the chief threat to the health of our nation today, but that we can give our children "secret weapons" against them.

Remove Handicaps

These secret weapons he defined as the cultivation of good health habits and the removal of all correctible handicaps in childhood.

"The dramatic progress in child health is clearly demonstrated by the very large and continuous reduction in the mortality of children and the substantial evidence that present day youngsters are heavier and taller than those of a generation ago."

In terms of positive health, more attention needs to be focused on the physical impairments, including poor nutrition, emotional disorders and other handicaps which are not a direct threat to life, but which may interfere with the child's education and affect his health in later years," Dr. Wheatley said.

Health Joint Responsibility

The conference also heard Dr. W. W. Bauer, director of health education for the American Medical Association, explain that the health of the child during his school years is the responsibility of the home, the medical and dental professions and the school. He expressed hope for better cooperation among these groups through closer acquaintanceship, personal and professional, and better understanding of viewpoints and aims, and smoother teamwork.

Clyde Parker, Superintendent of Schools of Cedar Rapids, Iowa, suggested that doctors should give more time to health counciling of parents and children.

"Doctors and dentists may find it hard to give time, but they must give attention to school health programs or others will do the job for them," Parker said. He made it clear that he was unalterably opposed to socialized medical programs, but warned that compulsory programs may take over unless doctors and dentists voluntarily give more attention to school health programs.

Dr. Carl N. Neupert, state health officer, said that "if a good job is done with children, a foundation is laid for a lifetime of sound health habits which are to the advantage of the individual, community and the nation."

Must Be Acquired

Dr. W. D. Stovall, director of the State Laboratory of Hygiene, reminded the conference participants that "health is not a privilege to be bestowed, it must be acquired. It can be acquired by the health of others around us. Health is a personal thing as well as a community responsibility. The physician comes in very strongly at this point because health is personal and the reactions of people are so different to various diseases that it is important to know him personally."

MEDICAL LEADERS discuss the program of the first Wisconsin Conference on Physicians and Schools. Left to right, Dr. A. H. Heidner, West Bend, past president of the society; Fred Holt, West Bend, chairman of the Wisconsin School Health Council and Dr. J. C. Griffith, Milwaukee, society president.

Photographer to Contact All Physicians Soon

Madison, Oct. 28.—During the coming months physicians and hospitals throughout Wisconsin will be contacted by Mr. Jerome Samuels, the official photographer of the American Medical Association.

The State Medical Society of Wisconsin is in the process of compiling a complete photographic record of all the doctors in the state. These photographs will be used in the activities of the medical society, such as the Wisconsin Medical Journal.

To facilitate taking of photographs of these physicians, the state medical society has asked all Wisconsin hospitals to cooperate by allowing Mr. Samuels to set up his equipment in the physicians' room of the hospital. While there he will obtain as many photographs as possible of the physicians on the staff and in the area.

No charge is made for the photographs, nor are the physicians under any obligation to purchase photographs. Mr. Samuels has been accredited by the state medical society to engage in this work.

Workshop Reports Place Stress on Doctor–Teacher Cooperation

Madison, Oct. 18.—More than 300 persons attended the first Wisconsin Conference on Physicians and Schools.

This conference was planned by the State Medical Society of Wisconsin in cooperation with the Wisconsin Cooperative School Health Council.

Dr. A. H. Heidner, West Bend, past president of the society, welcomed the participants to the conference and urged them to discuss with the physicians their problems and difficulties in the field of school health.

Dr. Heidner stressed the necessity of the examination of school children in the doctor's office. "In such a case, the doctor can evaluate the findings in the light of his knowledge with the previous history of the child and the family. If he finds an abnormal condition he can immediately start proper treatment, or arrange for further study or referral. I commend this plan to you with enthusiasm and urge you to give it careful consideration."

The major portion of the conference was devoted to workshop discussions of health examinations, control of disease, emergency care in schools, physical education, athletics and recreation, and the emotional problems of the growing child.

The following are summaries of brief reports presented by the chairman and recorder from each of the five sections:

Health Examinations

Dr. E. A. Pawsat, Fond du Lac, chairman; Dr. Maxine Bennett, Madison, recorder.

Health examinations should be done by a professional person, and the best one is the family physician. The nurse should act as a "go-between" between the school, parent and the doctor. The teacher plays an important role in preparing children for health examinations and teaching the need for continued good health. Health examinations are not only for the school children but for teachers and all employees. Ideally, health examinations should be scheduled for the pre-school age, sixth grade and high school age. Annual health examinations seem impractical. Accurate records of health examinations are good if they are used for effective follow-up. Percentage of families who follow through on recommendations made by the physician is increased when the examinations are done in the doctors office.

Control of Disease

Dr. George Shinners, Green Bay, chairman; Harley J. Powell, Wauwatosa, recorder.

Barriers to infection among school children are sterilization of the atmosphere with various devices and processes, increasing resistance through immunization, and isolation of children who have common colds and other infectious diseases, particularly in the early stages of the disease. Parents are urged to determine the child's fitness to attend school each day. Minor illness should not require permits to return to school, but reentry following a communicable disease should be granted only after a permit has been obtained from a qualified person. There is no experience indicating the advantage in closing schools during epidemics. Periodic health examinations were urged for all school personnel, including teachers and other employees.

Emergency Care In Schools

Leslie Johnson, Superior, chairman; Emma Erickson, La Crosse, recorder.

All persons on the school faculty should be trained in first aid. Each school should have a card file on each child providing the essential information on who to contact and what physician or hospital to call in the event the child is injured or becomes ill. Every school should develop a practical program of accident prevention. Each school should develop a written plan on how to deal with emergency situations and develop this plan in cooperation with the medical society and local health department, hos-

(Continued on page 1104)

THE HARDEST WORKING PARTICIPANTS at the 1952 Conference on Physicians and Schools at Madison, October 17–18, were the people shown above discussing the various reports they would give at the final session. The conference was the first of its kind in Wisconsin to be devoted to health problems of school children.

Left to right are: H. Kent Tenney, M.D., Madison, chairman, section on "Emotional Problems of the Growing Child;" George Shinners, M.D., Green Bay, chairman, section on "Control of Disease;" Ruth Palmer, Kenosha, recorder, section on "Physical Education Athletics and Recreation;" Fred Hein, Ph.D., Chicago, consultant, Bureau of Health Education, American Medical Association; Leslie Johnson, Superior, (Supt. of Schools), chairman, section on "Emergency Care in Schools;" Homer DeLong, Eau Claire, (Supt. of Schools), chairman, section on "Phy. Ed., Athletics and Recreation;" E. H. Pawsat, M.D., Fond du Lac, chairman, section on "Health Examinations;" Maxine Bennett, M.D., Madison, recorder, section on "Health Examinations;" Harley J. Powell, Wauwatosa, (Supt. of Schools), recorder, section on "Control of Disease;" Emma Erickson, La Crosse, recorder, section on "Emergency Care in Schools;" and Lloyd V. Ballard, Ph. D., Beloit, recorder, section on "Emotional Problems of the Growing Child."

WORKSHOP REPORTS . . .

(Continued from page 1103)

pitals, parents and school personnel. The State School Health Council was urged to revise the first aid kit equipment list so that it will be more timely. Detailed discussion of the W.I.A.A. program stressed the necessity of sending in reports on time, adherence to rules regarding play following an accident and familiarity with W.I.A.A. regulations.

Physical Education-Athletics-Recreation

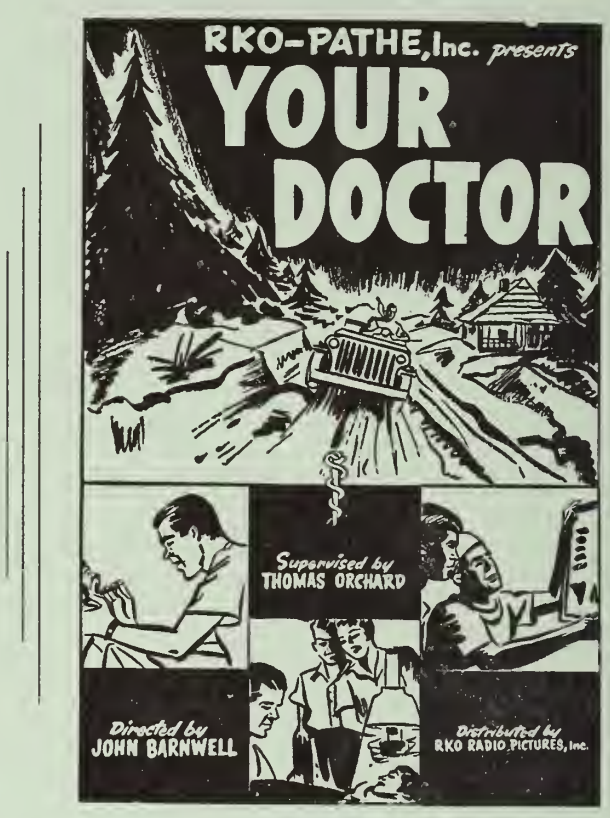
Homer De Long, Eau Claire, chairman; Ruth Palmer, Kenosha, recorder.

Physical education can make a very great contribution to human relationships. Recommended reading is the first-year book of the American Medical Association for health, physical education and recreation. A plea was made for greater understanding among parents and physicians of the purposes and goals of a physical education program. Teachers want closer understanding of physicians on reasons for excusing a child from physical education. Modified physical education programs are available for those finding extreme physical activity too strenuous. Too much time is being spent on varsity football and basketball and more time should be spent on intramural programs.

Emotional Problems of the Growing Child

Dr. H. Kent Tenney, Madison, chairman: Lloyd V. Ballard, Beloit, recorder.

Insecurity is the most significant cause of emotional problems of the growing child. This insecurity results from insecurity of adults at home being passed on to the children; emotional problems which confront the child as he begins his school experience; insecurity that comes when teachers proceed with education on a purely intellectual level ignoring the emotional aspects of the child's experience; and insecurity because the child entered school too soon. More teacher training is needed in the area of emotional problems Schools have an extensive responsibility in the area of detection and prevention of emotional problems.



Doctors Contact Local Theaters in Showing of Film "Your Doctor"

Madison, Oct. 28.—At least twenty Wisconsin theatres have shown the film "Your Doctor," produced by RKO in cooperation with the American Medical Association. Dr. George F. Lull, secretary and general manager of the American Medical Association, has stated that the film is "an honest portrayal of the role played by physicians in our country today. The film tells such a well-documented story that the American Medical Association feels every American should see it."

Many Have Shown

Reports from W. A. Blaney, manager of RKO Radio Pictures, Inc., 732 West State Street, Milwaukee, indicate that the following theatres have already shown the picture:

Glarus Theatre, New Glarus; Plainfield Theatre, Plainfield; Hancock Theatre, Hancock; Rudolt Theatre, Columbus; Vilas Theatre, Eagle River; Florence Theatre, Florence; Aqua Theatre, Minocqua; Home Theatre, Portage; Juliar Theatre, Baraboo; State Theatre, Rhinelander; Falls Theatre, Menominee Falls; Temple Theatre, Viroqua; Majestic Theatre, Beloit; Delavan Theatre, Delavan; Rivoli Theatre, Two Rivers; Badger Theatre, Stoughton; Park Theatre, Waukesha.

All county medical societies are urged to contact theatre managers in an effort to interest them in showing the film in their theatre. Further details about the film are available from the State Medical Society.

Promotional materials including postcard mats, newspaper advertising, still photographs, and news releases are available from the Medical Society to assist in promoting the picture locally.

Mr. Blaney reports that with Medical Society assistance throughout the State, including the efforts of the local physicians, he believes that the film "Your Doctor" will be shown in practically every theatre in Wisconsin.

Proceedings of the Milwaukee Academy of Medicine, May 20, 1952

The Application of Modern Chemistry to Medicine

By JOHN P. PETERS, M. D.
New Haven, Connecticut

IT IS impracticable for every clinical laboratory to do all the chemical tests that may be informative. Some require such expensive equipment, expert operation, and constant attention that they can be set up profitably only where there is special interest in the procedure and assurance of a continuous volume of work. Such services can be made available only by centralized services which are particularly adapted to procedures that do not require immediate analysis nor urgent answers. The average laboratory must confine itself to a limited number of procedures selected for their intrinsic value. The feeling that analyses need not be conducted with as meticulous care for clinical purposes as they must be for research work seems to me indefensible. The utmost precision in the laboratory can not assure reliable results without the intelligent cooperation of the clinician, who must know enough of the principles and significance of a procedure to know when it may be useful and how to interpret it. Specimens must be collected at appropriate times and under suitable conditions. Ignorance or disregard of these principles on the part of the physician not only detracts from the value of the test he requests, but discourages the chemist and contributes to his deprecatory attitude toward clinical work. Few chemical analyses can be interpreted unconditionally; they must be evaluated in relation to one another and in relation to the general condition of the patient.

Measurements of blood sugar can be of the greatest value in the detection and diagnosis and in the regulation of diabetes, especially the management of complications and critical states, including acidosis. The introduction of insulin and recognition of the effects of diet and activity have introduced new variables. Whether knowledge of the postabsorptive blood sugar is useful for the regulation of diabetes is arguable.*

The postabsorptive nonprotein nitrogen in the blood of normal persons receiving usual diets and adequate fluid seldom exceeds 40 mg. per cent. Removal or destruction of 50 per cent or more of the kidney is compatible with a normal nonprotein nitrogen. The blood nonprotein nitrogen is determined by the relation of the rate of protein metabolism to the excretion of the metabolic products. Dehydration or circulatory failure may impair the excretory function of kidneys that are structurally sound. Administration of excessive amounts of protein or excessive destruction of body protein may impose a burden that surpasses the excretory capacity of normal kidneys. If the kidneys are diseased, these secondary disorders have an exaggerated effect. The physician must, therefore, assess the general status of a patient with elevated nonprotein nitrogen to ascertain how far this may be the product of decompensation rather than insufficiency. It may be possible to remedy decompensation by corrective or supportive measures; it is not possible to provide new kidney substance.

Measurements of both nonprotein nitrogen and urea are superfluous since variations in the nitrogen of nonprotein compounds other than urea in the blood are usually insignificant. Nonprotein nitrogen is to be preferred because it is an essential part of the determination of serum proteins and nitrogen metabolism. Although urea clearances are elegant methods for the evaluation of renal function, they are not practicable clinical procedures because they involve the measurement of the excretion of urea during an exact interval of time definitely related to the time when the blood is drawn for analysis. The greatest precision in the laboratory can not correct failure to collect urine at the prescribed intervals. Because the production of creatinine is little affected by variations of protein metabolism, it is more nearly a criterion of renal insufficiency than is either nonprotein nitrogen or urea. On the other hand, it is a far less sensitive index of renal disability.

Blood uric acid has been widely accepted as a means of diagnosing gout, although it has proved to be highly nonspecific. It has been reported frequently elevated in nongouty states, especially diseases of the arteries and kidneys, and normal in patients with authentic gout. These anomalous results may be partly referable to the nonspecificity of the analytical procedures usually employed. Only serum or plasma is suitable for analysis, and this must be analyzed before and after the uric acid has been destroyed by the enzyme, uricase. This greatly complicates a procedure that already presented serious technical difficulties, especially in the maintenance of reagents and standards. It seems doubtful

*Some clinicians believe a blood sugar taken one hour postprandially has more significance.—Ed.

whether the installation and maintenance of such a laborious procedure in the average laboratory for occasional use is justified.

For the measurement of the plasma proteins in the battlefield, the ingenious specific gravity method devised by Van Slyke was invaluable. Its use in clinical laboratories is only an example of the efforts that have been made to evade the rigorous requirements of good chemistry. Sugar and nonprotein nitrogenous constituents, especially the former, have a large effect on specific gravity. The method, therefore, yields erroneously high values for protein in the presence of hyperglycemia or azotemia. Proteins should be fractionated into at least the two major components, albumin and globulin, by one of the newer procedures such as the Milne-Majoor or Pillimer technics that separate these fractions sharply. Reduction of albumin usually indicates the reaction to injury, malnutrition, or proteinuria; elevated globulin may arise from chronic infections of certain kinds, advanced hepatic insufficiency, or infiltrating diseases such as Boeck's sarcoidosis or plasmacytosis.

The concentration of calcium varies with the concentration of protein in the serum and is also affected by the concentration of inorganic phosphorus. The significance of serum calcium can not be evaluated, therefore, unless serum inorganic phosphate and serum protein, as well as its fractions, are also known.

For the evaluation of acid-base and osmotic equilibria of the blood, the concentrations in the serum of bicarbonate, chloride, and sodium should be measured. The pH of blood from peripheral regions may vary from region to region, according to local conditions. Besides, measurement of pH requires such rigidly anaerobic treatment of blood and such meticulous technic that it is impracticable as a routine laboratory procedure. Analysis of whole blood for electrolytes is futile since the distribution of all electrolytic components between cells and plasma is so uneven. Addition to blood of anticoagulants, with the possible exception of heparin, must be avoided because such anticoagulants add electrolytes to the plasma and cause transfers of water and anions between cells and plasma. Blood for electrolyte analysis should be drawn without venous stasis and protected against contamination with air by the technics devised by Austin, et al, and described by Van Slyke, myself, and others. Measurement of the carbon dioxide capacity of the serum gives a relatively rough idea of its carbon dioxide content as it was in the circulating blood. In order to evaluate the acid-base or anion-cation equilibrium of the serum, values for all electrolytes should be recorded in terms of combining equivalents, milliequivalents per liter.

Sodium is the predominant cation of serum; sodium salts make up 95 per cent of the total electrolytes. Since electrolytes are the chief osmotically active components of the serum, sodium serves as a measure of osmotic pressure, the factor that determines the distribution of water between cells and extracellular fluid. The anions are chiefly composed of bicarbonate and chloride. Only these 3 ions, sodium, chloride, and bicarbonate, occur in large enough quantities to influence seriously either the acid-base or osmotic equilibria of the serum. Ordinarily the sum of chloride plus bicarbonate is almost equal to the concentration of sodium; the difference, $Na-(Cl + HCO_3)$, termed undetermined acids, is small and relatively constant. Reduction of bicarbonate may result either from displacement of bicarbonate by other anions, for example, in diabetic acidosis by ketone acids, or from loss of sodium. If only bicarbonate or bicarbonate plus chloride is measured, these two conditions can not be distinguished, although their clinical significance and therapeutic implications are quite different. Since the introduction of the flame photometer, sodium can be measured rapidly and accurately. There is no longer any excuse for omitting it in the analysis of disturbances of hydration or acid-base equilibrium. The same instrument has facilitated measurement of potassium, which has proved of great value. Indirect estimation by nonspecific electrocardiographic changes is a poor substitute for direct analyses.

The measurement of protein-bound iodine—or better still, butanol extractable iodine—of serum has greatly enhanced our powers to diagnose disorders of the thyroid and regulate their treatment.

The excretion of ketosteroids and corticosteroids in the urine is an aid to the diagnosis of adrenal and pituitary disorders.

Finally, it is time to abandon the use of total cholesterol, especially when it is estimated by simplifications of the Liebermann-Burchard color test, as a simple measure for serum lipids. Accurate measurement and fractionation of these compounds is a difficult chemical procedure, but the only road to the solution of disorders of lipid metabolism.

These points have been selected as examples of the direction practical clinical chemistry must take if its full value is to be realized.

Yale University School of Medicine.

ANNOUNCEMENT FROM THE AMERICAN COLLEGE OF CHEST PHYSICIANS

The nineteenth annual meeting of the American College of Chest Physicians will be held at the Hotel New Yorker, New York City, May 28–31, 1953. Physicians who wish to present papers at the meeting should submit titles and abstracts to Dr. Arthur M. Olsen, Chairman, Committee on Scientific Program, American College of Chest Physicians, Mayo Clinic, Rochester, Minnesota.

Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

More About the Question of Anticoagulants in Coronary Accidents

A year ago the writer presented in this column a discussion of the clinical use of anticoagulants in instances of coronary accidents and the evident infarction which often follows. Studies of the use of anticoagulants are still being reported, and it is the opinion of the writer that the peak of the wave of popular enthusiasm for this means of treatment is being reached. As in the instance of many other new means of therapy, the early blush of anticipation for a new agent sooner or later fades to a justifiable level, so here one can see a definite trend away from the early expectation for a new agent which was hoped to be the fulfillment of a serious need.

In our *Comments* of November 1951, we referred to Russek *et al.* and their grouping of hospital patients into two classes: (a) those patients with a good prognosis and (b) those with unfavorable signs and symptoms, i.e., good risk and poor risk patients, respectively. In the latter group[1] are those with (1) previous myocardial infarction, (2) intractable pain, (3) shock, (4) cardiac enlargement, (5) gallop rhythm, (6) congestive heart failure, (7) auricular flutter or fibrillation, or ventricular tachycardia, (8) diabetic acidosis, marked obesity, previous pulmonary embolism, or "other conditions predisposing to thrombosis."

A series of 1,047 consecutive "cardiac" cases[2] were diagnosed on admission to the hospital as acute myocardial infarction and all were treated by conservative means without anticoagulants. On classification on the day of admission, which was for the most part the day of their accident, there were 489 falling into the good risk class and 558 were considered as poor risks. Succeeding events produced a mortality rate of 3 per cent of those in the good risk group and 60 per cent in the poor risk class. There were four instances in the good risk group developing embolisms and 59 instances in the poor risk class, making 0.8 and 10.6 per cent, respectively. Of the 15 cases of death occurring in the good risk group, 7 occurred in the hospital within 48 hours. There was one instance of cerebral embolism, together with four others where permits for autopsies were not obtained. It might be assumed that these deaths could have been prevented by anticoagulant therapy, which brings the possibly preventable number of deaths to about 1 per cent. This figure of 1 per cent should be compared to the percentage incidence of major hemorrhage following anticoagulant therapy, namely, from 2 to 10 per cent, with a death rate given as 0.2 per cent. This could mean no less than the absolute necessity of rigorous control of coagulability whenever anticoagulant therapy is instituted.

In regard to the question of age as a factor, this series of deaths revealed no evidence that age was of any significant importance within either the good risk or within the poor risk group. Thus, the prognosis depends on the severity of the symptoms, placing them in one or the other of the groups, rather than on age *per se*.

Finally, the authors conclude, from the marshalling and analyzing of available evidences, that the routine employment of anticoagulants in the treatment of acute myocardial infarction is quite undesirable and unnecessary.—A. L. TATUM, M.D.

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2. Russek, H. I., and Zohman, B. L.: An evaluation of anticoagulant therapy in the treatment of acute myocardial infarction, Am. Heart J. 43:871–880 (June) 1952.

AMERICAN ACADEMY OF DERMATOLOGY AND SYPHILOLOGY TO MEET IN CHICAGO

The eleventh annual meeting of the American Academy of Dermatology and Syphilology will be held December 6–11 in the Palmer House, Chicago.

Principal sessions will be held in the hotel Monday through Thursday, December 8–11, and special courses in histopathology, mycology, x-ray and radium, bacteriology of the skin and research methods of dermatology will be held Saturday and Sunday at the college of medicine, University of Illinois, Northwestern University, Billings Hospital, and in the Palmer House.

For further information write to the American Academy of Dermatology and Syphilology, 82 West Washington Street, Chicago, Illinois.

Teamwork for the Best Start in Life

As It Looks to the State Board of Health

THE fetal and neonatal periods now offer the greatest opportunity for saving the lives of Wisconsin babies. Deaths from these groups combined took 34 of every 1,000 babies born in 1951 and weights showed that by far the most constant factor was "premature birth." Recent studies have shown that attention must be focused on the prenatal and delivery period since about 85 per cent of these deaths are traceable to problems associated with pregnancy or delivery. Combating this loss of life therefore presents a challenge to be met earnestly and zealously by every physician caring for expectant mothers.

First we are confronted with the upward trend in premature deliveries. The causes certainly are not clear but the facts show that there were only 1,293 premature births or 2.4 per cent of total live-births in 1937 compared with 5,484 or 6.2 per cent in 1951. It is little wonder that our facilities have been taxed and that additional attention must be given to finding possible causes. The fairly wide variation in the per cent of premature births among counties and even among hospitals offers some hope for a solution. If premature interruptions of pregnancy could be kept to the minimum, progress would be rapid. Maternal complications need further analysis, and greater effort must be made to find common factors in cases for which there is no apparent cause. Here are some of the things which physicians, as individuals or in groups, may wish to review.

- Are all Wisconsin mothers seeking and receiving adequate prenatal care throughout pregnancy, including blood tests, pelvic measurements, and general health instruction
- Do patients understand fully the importance of an adequate diet, particularly during pregnancy, and are they able to obtain it
- Are patients alerted to unusual symptoms that they seek and receive prompt medical attention, with consultation when needed
- Are cooperative community efforts made to help patients approach pregnancy, delivery, and parenthood without needless apprehension
- Are hospital facilities, technics, and practices adequate
- Does each hospital regularly review maternal, fetal, and infant deaths
- Are physicians and patients familiar with community services available

Secondly, while we study means of reducing the incidence of premature deliveries we must recognize and meet the needs of the prematurely born infant.

- Is the use of analgesia and anesthesia kept to a minimum, particularly in premature deliveries
- Are isolation facilities, good nursing care, oxygen, and heated beds always available
- Is the premature baby's health carefully appraised and his care guided by the physician
- Are parents guided in financial, environmental, or emotional adjustments that a premature birth may create

Professional groups can find a fresh approach to prenatal and neonatal care in the film "A Concept of Maternal and Neonatal Care" directed by Drs. John Parks and Preston McLendon. It emphasizes the need for interrelation of services, optimal patient-physician relationship, education for a relaxed labor, and the development of a happy relationship between new parents and their infant. The doctor, nurse, and hospital administrator operate as a team from early in pregnancy with resulting growth of confidence, maximum comfort, safety, and protection of the mother. Although the film emphasizes the specialists, whereas in Wisconsin most of the deliveries are by general practitioners, the suggestions made apply to anyone caring for expectant mothers. Particularly good are the suggestions for recognizing emotional tensions and allowing young expectant parents to ask their own questions so as to release fears and develop greater readiness for parenthood. The hospital begins its service when expectant parents visit to learn hospital routines prior to delivery. It also creates opportunities for a close family relationship and teaches parents to care for their babies. Various means of developing rooming-in are applicable to Wisconsin situations. Local medical societies or hospitals may wish to use this film which is now available from the Wisconsin State Board of Health.—AMY LOUISE HUNTER, M. D., Dr. P. H., *Director, Section on Maternal and Child Health.*

MARQUETTE MEDICAL ALUMNI, ATTENTION

The Marquette Medical Alumni Association will hold its annual Spring Clinics at the Medical School on Saturday, March 28. Make a note of this date now. Further details will be given in subsequent issues of the *Journal.*

Clinicopathologic Conference

Editors—W. A. D. ANDERSON, M. A., M. D., Marquette University School of Medicine, Milwaukee and D. M. ANGEVINE, M. D., University of Wisconsin Medical School, Madison

REPORT OF A CASE*

History: A 16 year old white farm girl entered the hospital for the first time with nausea, vomiting, hemoptysis, and melena. She had been well until one month previously when she had noted dyspnea while climbing stairs, accompanied by slight dizziness, "a sort of headache," and palpitation. These symptoms became progressively worse, and a substernal pain and feeling of faintness were added. At this time the patient had a sore throat and coughed frequently, especially at night; the cough was productive, at times containing bright and dark red blood, while a pain in the upper chest was present. Hospitalization in the local hospital occurred two weeks after onset, and a chest x-ray was interpreted as a virus pneumonia, while miliary tuberculosis and leukemia were considerations. Treatment with oxygen and penicillin and liver was given, resulting in the development of hives which disappeared after medication was stopped. Anemia was noted and 5 blood transfusions were given. The patient improved and soon became ambulatory, but retained a tired feeling and anorexia. During her 18 day hospitalization she lost 9 pounds and was told that blood was present in the urine. The patient described her urine as being red to brown in color, which she had never noted before. No urinary complaints or history of urinary tract infection were present. One week after her discharge the patient was admitted to Wisconsin General Hospital. She had been well the first 2 days; then the anorexia became a slight nausea followed by vomiting, with a red to brown colored vomitus. The next day her stools became black and tarry, while a dull ache was present in the lower abdomen. Five days after her discharge she was readmitted to the local hospital with vomiting, hematemesis and melena, and she received a blood transfusion during which a shaking chill started which lasted five hours.

On her admission here blood had persisted in her urine and she felt sleepy and tired. No edema or oliguria had been present, nor was there bleeding from gums or petechial hemorrhages. Her past history indicated headaches for the past year with no definite location. No epistaxis had been present. No history of nocturia or of any previous genitourinary disease was given. Her last menstrual period was 10 days early, which was unusual for this patient. Her past medical record reviewed her health as good. Only known illnesses in her history were measles and the virus pneumonia mentioned previously, no rheumatic fever or scarlet fever, appendectomy at age 8, and no family disease history.

Physical Examination: The patient was a well developed, well nourished, slightly obese female, somewhat pale but alert and cooperative. Admission temperature was 99.6 F. and blood pressure 140/75. No palpable nodes were found. No petechiae were seen. Examination of the eyes, ears, nose, and throat was unremarkable except for a pallor of the mucous membranes. Lungs were clear to auscultation and percussion. The left cardiac border was 8 cm. from the midsternal line. There was a normal sinus rhythm with rather frequent premature contractions, and a grade 2 systolic murmur over the apex and base was heard, as well as some reduplication of the second pulmonic sound. The pulmonic sound was greater than the aortic. The abdomen showed a normal aspect of palpation. Infrequent bowel sounds were heard on auscultation. Rectal examination showed only dark gray to black stools. No edema was present. Neurologic examination was not remarkable.

Laboratory Studies: At the time of the patient's admission in the local hospital, laboratory studies showed 2,300,000 red blood cells and 6,600 white blood cells, 392,000 platelets, and a nonprotein nitrogen of 93 mg. per cent. Urinalysis showed many red blood cells. Urine on admission was bloody, had a specific gravity of 1.015, acid reaction and 0.3 to 0.4 per cent albumin. Sediment showed 0 to 2 white blood cells and many red blood cells per high power field, as well as 0 to 1 casts, granular and hyaline, per low power field. The blood showed a hemoglobin level of 7.75 Gm., 2,200,000 red blood cells, and 8,050 white blood cells, with 75 per cent neutrophils, 1 per cent bands, and 24 per cent lymphocytes. Sedimentation rate was 17 mm. per hour, and hematocrit index was 20 per cent. Blood chemistry showed 105 mg. per cent of sugar, a nonprotein nitrogen level of 180 mg. per cent, and creatinine 22 mg. per cent. Serology and routine agglutinations were negative. Prothrombin time was 70 per cent, and serum proteins were 5.6 Gm., with 4.2 Gm. albumin and 1.4 Gm. globulin. Serum sodium was 143 milliequivalents per liter and potassium 6.18 milliequivalents per liter. Carbon dioxide-combining power was 40 volumes per cent. Hanger's test was negative. Nose and throat cultures were negative for Klebs-Löffler bacilli; catheterized urine showed only diphtheroids. Blood cultures showed no growths. Initial electrocardiogram showed a first stage auriculoventricular block with low voltage. Chest x-ray showed pulmonary edema, most likely of renal origin. Abdominal x-rays were normal except for a small calcareous density in the left upper pelvis.

* From the University Hospital and University of Wisconsin Medical School.

Course: On the second evening the temperature rose to 101.0 F. Complaints of nausea and vomiting continued, and a slight left costovertebral angle pain was present. Urine output on the second day was 200 cc. Treatment consisted of intravenous fluids, not over 1,500 cc. of 5 per cent glucose in water. On the third day administration of ACTH was started, 25 mg. every 6 hours intramuscularly. An attempt was made at peritoneal lavage through a polyethylene tube in the left lower quadrant but was unsuccessful and discontinued after 24 hours. Urinary output dropped to 65 cc. on the third day and to 30 cc. on the fourth day; and the patient was anuric for the rest of her stay. Hemoglobin level dropped to 4.2 Gm. and the red cell count to 1,100,000 while the white cell count rose to 16,250. A transfusion was given without apparent reaction, but the next day the icterus index was 18 units. Nonprotein nitrogen remained 180 mg. per cent for 5 days and then rose to 222 mg. per cent. The patient became more lethargic, continued having nausea and retching, and some edema of the face and legs developed. Intravenous aureomycin was given because of the possibility of infection at the site of lavage. On the seventh hospital day the nonprotein nitrogen rose to 292 mg. per cent, and an attempt was made to pass an intestinal tube for irrigation. Nine days after admission the patient had muscular twitchings. She remained lucid, but increased irritability and mental slowing were present. The patient died that day after a more severe convulsive episode.

Clinical Discussion

Dr. D. E. Olson: This patient had multiple problems which involved numerous systems, but it is quite obvious that the primary pathology and symptomatology centered about the renal system and that the patient died in a terminal uremia.

However, as one reads the protocol, ample evidence is found of involvement of the respiratory, gastrointestinal, vascular, hemopoietic, and central nervous systems. Fortunately for us there is no evidence of involvement of the musculoskeletal or peripheral nervous systems. It would be convenient for me to piece this puzzle together and arrive at a single diagnosis to explain the multiple symptoms and signs, and I think this can be accomplished. It is my feeling that the patient had acute glomerulonephritis. However, at these conferences it usually behooves one to discuss some aspects of a differential diagnosis, therefore I shall proceed to elaborate on some points of differential diagnostic significance.

There is evidence of involvement of the hematopoietic system. This patient had hemoptysis, melena, hematemesis, hematuria, and anemia. She also had multiple blood transfusions. These facts immediately suggest the possibility of a blood dyscrasia. Further weight is given to such a diagnosis by the chest x-ray report from her local hospital which gave consideration to a diagnosis of leukemia; however, I do not feel that this is a likely diagnosis for these reasons:

(1) From a clinical and physical standpoint there was no evidence of bleeding from the nasal cavities, bleeding into the skin, etc.

(2) There was no evidence of splenomegaly or peripheral lymphadenopathy.

(3) The laboratory examination showed a prothrombin time of 70 per cent which is not low enough to allow massive hemorrhage from any site.

(4) The blood platelets were 392,000 which is within normal limits.

If one were to give serious consideration to a blood dyscrasia, it would be helpful to have further studies such as bleeding time, coagulation time, Rumple-Leede test bone marrow, etc., but the people on the wards obviously had other problems, and these tests were not indicated. Therefore, I think that one can dismiss blood dyscrasia as a diagnosis.

First let us consider the respiratory system which played a dominant role in this patient's symptomatology and clinical course. In reviewing the protocol I can not think of a lesion of the respiratory system which would give rise to such general systemic disease as this patient displayed, unless it were pulmonary tuberculosis with miliary spread. This patient's course, her laboratory findings, etc. do not substantiate this diagnosis, even though miliary tuberculosis was considered in the initial chest x-ray. If one were to consider miliary tuberculosis, he would like to know the results of tuberculin skin tests, sputum examination, and the cultures of the urine for acid-fast bacilli. Certainly the patient's urinary findings did not substantiate a diagnosis of tuberculous pyelonephritis. For these reasons I think one can eliminate the respiratory tract as the seat of primary pathology.

The gastrointestinal tract also played a predominant role with multiple symptoms referable to it, but again it is impossible for me to postulate a primary major disease of the gastrointestinal tract which would cause such general systemic manifestations and severe renal problems as this patient displayed.

It is a little more difficult to eliminate the diagnostic possibility of a diffuse collagen disease. The two most likely considerations are polyarteritis nodosa and lupus erythematosus disseminata. One can quickly eliminate the diagnoses of scleroderma and dermatomyositis by the absence of skin and musculoskeletal changes. Likewise, lupus can be quickly dismissed as the patient had no typical skin lesions, splenomegaly, lymphadenopathy, typical leukopenia, or history of arthralgia. This course is also rather short for a patient with lupus erythematosus. Polyarteritis is a definite consideration. This course, however, is again a little short for that disease. Generally males are affected by polyarteritis much more predominantly (4:1) than females. In polyarteritis over a quarter of the patients have some eosinophilia, which this patient did not have. To make a diagnosis of this disease clinically is often an exceedingly difficult task, and one must rely largely on biopsies. It is hard for me to believe

that polyarteritis would produce such severe gastrointestinal bleeding, renal pathology, or hemoptysis as this patient had.

That brings us to a consideration of primary renal pathology. The renal disease was acute. The patient's total course was not over 5 or 6 weeks. It is possible that she had an acute pyelonephritis. However, clinically she did not have initial sweats, costovertebral angle pain, symptoms of dysuria, frequency, nocturia, etc. Also the laboratory evidence did not substantiate a diagnosis of pyelonephritis. There was a lack of white blood cells in the urine; only a few were found. The casts were primarily hyaline; they were not the cellular casts that one associates with an acute pyelonephritis. We are told that the catheterized urine specimens showed diphtheroids on culture, but this was probably a contaminant. Blood cultures were negative. For these reasons I feel that the diagnosis of pyelonephritis cannot be substantiated.

That brings us back to the original diagnosis of acute glomerulonephritis. Usually this is a disease of the younger age group (5 to 10 years), and it predominantly occurs in males. However, these two facts do not disprove the diagnosis in this individual. The disease can occur in any age group, and it does occur in females. Practically always, if not always, the disease is preceded by an infection which is usually in the upper respiratory tract. The etiologic agent of the infection is the beta hemolytic streptococcus. This is where the patient's respiratory symptomatology seems to enter the picture. One notes that at the onset of her illness she had some nonspecific complaints such as dizziness, palpitation, and headache plus a sore throat, cough, hemoptysis, and chest pains. These symptoms led me to believe she had an upper respiratory tract infection, the etiology of which was unknown. However, I speculate that it was a streptococcus infection. The x-rays taken at that time were diagnosed as virus pneumonia, but that diagnosis was not conclusively established. It is possible that the patient had bronchopneumonia. I feel confident that she at least had a severe tracheobronchitis which was responsible for her hemoptysis. In these circumstances one had the background for the development of an acute glomerulonephritis. Usually there is a symptom free interval, but it is not impossible for the patient to go immediately into the renal phase as this patient did. When she was hospitalized, she was told that her urine contained blood and she stated that her urine was red to brown. Usually with acute glomerulonephritis the urine is smoky or brown in color; it is not red as it is in tumors of the kidney, acute pyelonephritis, etc. where there is bleeding into the renal pelvis. In acute glomerulonephritis blood is filtered through the diseased glomeruli and, during passage through the tubule, hemoglobin is released from the red cells. Hemoglobin is converted in the acid medium into acid hematin which is brown in color and irritating to the tubule. I think that this phenomenon explains her brown urine.

As I have indicated, her symptomatology was very diffuse and involved many systems. She had a moderate elevation of temperature, headache, some dyspnea, nausea, vomiting, and anorexia. All of these symptoms are commonly present in acute glomerulonephritis. In the physical examination there were important findings. One was the blood pressure of 140/75. This was mildly hypertensive for a patient in this age group. In acute glomerulonephritis at least 60 to 70 per cent of patients will have a mild to moderate elevation of blood pressure. It would be interesting to know if there was a progressive increase in this patient's blood pressure during her hospital course. I suspect that there was. The second interesting finding in the initial physical examination was a lack of clinical edema. This did develop, however, as a terminal phase. Edema does develop commonly in these patients, but it is usually minimal.

Laboratory examinations supported a diagnosis of acute glomerulonephritis. There was marked evidence of hematuria and some proteinuria, the albumin being 0.3 to 0.4 per cent. There were few white cells and casts. Severe renal involvement was indicated at the beginning of hospitalization as the nonprotein nitrogen was 180 mg. per cent and the creatinine was 22 mg. per cent. Subsequently the nonprotein nitrogen rose which indicated progressive renal damage. Besides the glomerular damage, I feel that there probably had been tubular damage. The etiology of the tubular damage might have been secondary to the glomerulonephritis or possibly due to blood transfusions which the patient received. After one transfusion she had shaking chills for 5 hours and after another the icterus index was recorded as 18 units. With these transfusion reactions it is possible that more hemoglobinuria occurred and the hemoglobin was converted to acid hematin which further damaged the tubules. The tubular damage was manifested in this patient primarily by the rather low specific gravity of 1.015. Generally in acute glomerulonephritis, oliguria occurs and progresses to anuria as it did here. The urine is generally hypersthenuria, but when it is hypersthenuric the prognosis is much more grave. It was proved to be so in this case.

I said at the outset that I thought this patient died in clinical uremia. From the laboratory standpoint we have ample evidence to support such a contention. I think the uremia can easily explain this patient's terminal severe respiratory tract involvement. A chest x-ray was compatable with the diagnosis of pulmonary edema, most likely due to renal involvement, and I would anticipate that at autopsy this patient had severe pulmonary edema and congestion and probably mild terminal bronchopneumonia.

Also, I feel that the acute glomerulonephritis and uremia can explain the patient's cardiovascular symptomatology and signs. From 75 to 80 per cent of patients with this disease have some involvement of the cardiovascular system and electro-

cardiogram changes. Myocarditis or toxic disturbances could have produced the patient's first stage auriculoventricular block and low voltage on the electrocardiogram. In the initial physical examination frequent premature contractions were found and these do occur in these diseases. Furthermore, the elevation in the patient's serum potassium and the probable decrease in the calcium could lead to further abnormalities in the cardiac rhythm. Commonly it is the abnormality of cardiac rhythm produced by the electrolyte disturbance which causes death in these patients. Another common finding in a severe uremia is pericarditis. There is nothing in the protocol which suggested pericarditis, but I suspect that at the autopsy table some evidence of it was found. Uremia may also give rise to anorexia, nausea, vomiting, and bleeding. I would anticipate that this patient displayed necrosis and ulcers of the stomach, small intestine, and colon. Ulceration and bleeding from the gastrointestinal tract was probably a partial source of the patient's profound anemia. An additional factor in the anemia could be a toxic effect of the renal disease on the bone marrow.

I still have to explain the patient's central nervous system signs and symptoms. Again the uremia could have been an adequate explanation. Symptomatically the patient had dizziness, lethargy, and stupor. Terminally she had convulsions. The alterations in electrolyte balance probably were responsible for these central nervous system symptoms and signs.

In summary I feel that this patient had acute glomerulonephritis with severe involvement of the glomeruli and moderate changes of a degenerative character in the distal convoluted tubules. Secondly, I feel that she had pulmonary edema, pulmonary congestion, and minimal bronchopneumonia. Third, she had superficial necrosis and ulcerations of the stomach, small intestines, and colon. Fourth, there was probably some element of myocarditis, possibly pericarditis, and some cardiac dilatation. Fifth, I think that she had minimal peritonitis subsequent to the attempted peritoneal lavage.

X-Ray Report: **Dr. W. M. Rounds:** A chest film made approximately 8 or 9 days prior to death showed a cardiovascular shadow within normal limits. There was a loss of aeration in the central lung field extending out from the hilum to the midzone. There was a general hazy increase in density which was fairly symmetrical on the two sides. The shadows faded off into the midlung fields, and in the peripheral zones there was quite good aeration of the parenchyma. These changes were considered to be on the basis of pulmonary edema, probably of renal origin, or in other words, probably the so-called azotemic lung. That is not a particularly good term because this type of pulmonary change can occur in the absence of azotemia, and it may develop secondary to diseases other than those primarily renal in origin. However, it is seen quite commonly in association with glomerulonephritis, either acute or subacute and generally it indicates that that diagnosis is correct.

Dr. D. M. Angevine: Does anyone care to add to Doctor Olson's discussion? Doctor White, do you remember this case on the wards?

Dr. D. H. White: After the first day and receipt of the laboratory reports we were convinced that the patient had either acute or subacute glomerulonephritis. There was some question about a lower nephron nephrosis. She had a blood transfusion with a reaction, apparently with chills.

Doctor Angevine: What was your explanation for the loss of blood? Did you feel that there was enough loss through the kidneys to explain the picture? Of course she had some through the gastrointestinal tract.

Doctor White: No. We thought that she had a gastrointestinal lesion initially, and later it became fairly obvious that it was uremia and that the bleeding could be explained on the basis of uremia.

Doctor Angevine: Any other comments or questions?

Dr. O. O. Meyer: Doctor Olson has inquired about the blood pressure and anticipated a gradual rise, that was a correct assumption.

Necropsy Findings

(W.G.H. 51:245)

Dr. H. J. Van Baaren: The autopsy findings agreed with the clinical deductions except for a few minor points. Upon opening the gastrointestinal tract no blood was found nor could a source of bleeding be demonstrated. The only lesions observed were a few petechial hemorrhages in the wall of the stomach. Microscopy of the colon did not show any evidence of uremic colitis.

The hematopoietic system and the lymph nodes were essentially normal except that a few of the periaortic lymph nodes showed some hyperplasia. The bone marrow was a hyperplastic cellular marrow with an increase in erythropoietic centers as seen in many cases of glomerulonephritis. On opening the thorax a few hundred cubic centimeters of clear fluid were present in both pleural cavities. Three types of changes were seen. First of the changes was the fresh hemorrhage. In addition to this, a few pigmented macrophages were indicative of old hemorrhage. These macrophages were also seen in an area where there was no evidence of a fresh hemorrhage, which indicated repeated hemorrhage within the lungs. The third change was a clear, pink staining material in the alveoli indicative of edema. As far as the respiratory system was concerned, pleural exudate, recent and old hemorrhages, and pulmonary edema were seen.

The kidneys, in addition, showed a very definite change in every glomerulus visible and these severe changes were swelling, the unclear pattern of glomeruli, and the definite proliferation of the capsule of Bowman, which should lead to the formation of crescents in many cases. In this case, however, the proliferation was so severe that a generalized in-

crease without crescent shapes was seen. This proliferation led to compression of the glomerular tufts. Clinically, at least in the discussion, this case was diagnosed as acute glomerulonephritis; however, using a special Mallory stain for connective tissue, we found fibrosis starting in the glomeruli. In this case the glomeruli, or rather the lumen of the glomerular capsule, were filling with connective tissue which took the case definitely out of the range of an acute glomerulonephritis. The connective tissue forming within the capsule of Bowman led to the diagnosis of the case as subacute glomerulonephritis.

Doctor Angevine: I was discussing this case with Doctor Herrin this morning. He asked me if I thought that this much renal alteration could take place within the period of the history. I certainly think it could. In this case it is remarkable that practically no glomerulus had escaped. The uniformity of involvement of the glomeruli suggests that the kidneys were hit rather extensively at the same time. To answer the question of whether there was hemoglobinuric nephrosis present, there were hemoglobin casts in the tubules, but I question whether that was of a great deal of significance. I believe that some of the reaction may be attributed to the fact that if there was extensive destruction of the blood that the resultant hemoglobin could only have been cleared through the badly damaged glomeruli with great difficulty.

Dr. G. E. Magnin: Do you feel that hemoglobin is a renal tubule irritant?

Doctor Angevine: Doctor Lalich, from some of his experimental studies, feels that it is an irritant to the renal tubules and has a good deal of evidence to support his contention. Normal hemoglobin is probably not, but once the hemoglobin reaches the kidney tubules it is altered to oxyhemoglobin or some other compound which is irritating or toxic to the tubules.

Dr. R. C. Herrin: Many of my proposed remarks have already been expressed by Doctor Olson. The laboratory studies indicate, of course, extreme renal failure. The elevated nonprotein nitrogen of 92 mg. per cent, the progressive rise to 292 mg. per cent, and the blood creatinine of 22 mg. per cent, a 10 times increase over normal, both show a failure of the excretory function of the kidney. This degree of nitrogen retention indicates that the glomerular function in these kidneys was almost nil, because that is the sole source by which these materials are removed from the blood stream. This degree of glomerular failure would account for the oliguria and finally the anuria. Fluid simply was not being filtered to the tubules. It may account for the low cast count in the urine because there were relatively few nephrons contributing casts to the urine. That might also be due to a reduced amount of protein being delivered to the nephrons in terms of the blood flow and filtration at the glomerulus. The preservation of a normal blood sodium, here 143 milliequivalents, could also be explained on the basis of the greatly impaired glomerular function. There was no chance for sodium to be lost. The fact that the blood sodium remained approximately normal also indicates that clinically there was wise judgment used in administering fluids to this patient. Otherwise there might have been an overdilution. The 20 per cent increase in serum potassium might be explained on the basis of failure of glomerular filtration and the consequent excretion of potassium. Some workers, however, think that the increase in blood potassium in uremia represents a leakage of potassium from the cells rather than failure of excretion. Both could be a factor in this case. Another factor that might contribute to the azotemia was the loss of blood into the gastrointestinal tract. Large hemorrhages into the tract lead to an azotemia, the exact explanation of which is subject to some question. A failure in the acid-base regulating function of the kidney is also shown by the acidosis of the 40 volumes per cent of carbon dioxide. This renal function of regulating the acid-base balance is directly performed by the tubules, but to do that they have a delivery to them of phosphate via the glomerular filtrate. That was lacking here. There also is evidence that the enzymes concerned in the formation of ammonia, needed in combatting acidosis, are impaired in nephritis. With the almost complete glomerular failure one might expect a more severe acidosis than developed in this patient. Actually the carbon dioxide capacity can become much less than what it was. There is a history of vomiting in this case and to whatever extent the patient lost hydrochloric acid in the vomitus, to that extent would the acidosis then be corrected.

UROLOGY ESSAY CONTEST ANNOUNCED

The American Urological Association offers an annual award of $1,000 (first prize of $500, second prize $300, and third prize $200) for essays on the result of some clinical or laboratory research in urology. Competition shall be limited to urologists who have been in such specific practice for not more than five years and to men in training to become urologists.

The first prize essay will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Hotel Jefferson, St. Louis, Missouri, May 11–14, 1953.

For full particulars write the Executive Secretary, William P. Didusch, 1120 North Charles Street, Baltimore, Maryland. Essays must be in his hands before January 15, 1953.

Facts about

Blue Shield of Wisconsin

an agency of the State Medical Society of Wisconsin

Prepared by the Commission on Prepaid Plans of the State Medical Society of Wisconsin,
E. M. Dessloch, Prairie du Chien, Chairman.

CASE NUMBER	SUBSCRIBER'S CONTRACT NUMBER	NAME OF PATIENT	DATE MO	DATE YR.	AMOUNT PAID
92675	1282230	DODGE LUCILLE M	9	2	35 00
92675	1282230	DODGE LUCILLE M	9	2	60 00
93671	1282230	DODGE LUCILLE M	10	2	25 00
64328	2282100	JACOBS GEORGE R	9	2	15 00
76381	1634620	PETERSON JOHN	8	2	50 00

WISCONSIN PHYSICIANS SERVICE

THE BLUE SHIELD PLAN OF THE STATE MEDICAL SOCIETY OF WISCONSIN

MADISON WISCONSIN

DETACH BEFORE CASHING CHECK

Wisconsin Physicians Service
The Blue Shield Plan of the State Medical Society of Wisconsin — Madison, Wisconsin

79-46
715

00003

DATE 10 19 52

PAY EXACTLY 00185 DOLLARS AND 00 CENTS

$ 185 00
DOLLARS | CENTS

TO THE ORDER OF
JOHN J JONES MD
1622 MAIN ST
ANYWHERE WISCONSIN

WISCONSIN PHYSICIANS SERVICE
SERVICE BENEFIT ACCOUNT

TO THE FIRST NATIONAL BANK OF MADISON - MADISON, WISCONSIN

HERE IS THE NEW VOUCHER-TYPE CHECK now being used in paying Wisconsin Physicians Service claims. As this payment procedure becomes standardized it will mean reduced processing time and greater economy for WPS and participating physicians. An important explanation of this voucher-check is presented below.

All payments to WPS participating physicians are made on the two-part form shown above. The top portion is a voucher which can be used by the physician in crediting the patient's account. The lower portion is detached by the physician and processed as a check.

The two left-hand columns of the voucher section are for WPS purposes only. The physician uses the right-hand columns for accounting. Each name listed on the voucher represents a separate procedure for which payment is being made by the WPS check below. The date column shows the month and year the procedure was performed—9/2 meaning September 1952. The last column indicates the benefit provided by WPS for the procedure. When the same patient's name is listed more than once, it indicates that payment is being made for more than one procedure.

Participating physicians are usually paid once each month, although the volume of claims sometimes requires two payments a month. Although every effort is being made to reduce errors to a minimum, some may occur because WPS processes over 5,000 claims each month and the similarity of names may cause confusion.

If an error appears on a check and voucher which includes payment for more than one patient, the physician is requested to cash the check and send a refund check of his own for the erroneous payment.

If an error appears on a check and voucher involving only one patient, simply return the check and voucher to the WPS office and correction will be made on the next monthly payment.

. . . . THE PRESIDENT'S PAGE . . . .

THIS is my first opportunity to bring you a message on this page. As I see it, there are many problems that confront us as physicians, individually and collectively, in the rendering of good medical care without its being prohibitive in cost.

If voluntary insurance is to be the answer it must be made to work successfully. This requires the cooperation of both the physician and his patient. Insurance against the cost of medical and surgical care is on either a cash indemnity, a service plan basis, or a combination of the two. In Wisconsin we have all three, and I believe that they are generally satisfactory.

In a recent bulletin to its locals, the UAW–CIO alleges that doctors commonly charge more than scheduled allowances provided by insurance and that if premiums and fee schedules are increased doctors' charges will still exceed the scheduled allowance in most cases, so that the employee is required to pay twice, once for the insurance and again for an additional fee. They further charge that in service plans such as Blue Shield and the Wisconsin Plan, the income ceiling under which the full payment guarantee is extended to workers is often too low to offer a real protection for most workers. They also contend that in their experience the schedule was most nearly adequate in minor operations but when it came to the more expensive operations, when protection was needed, the doctors' charges exceeded the scheduled allowance in nine out of ten cases.

Blue Shield plans were originally conceived to bring necessary medical service to people of limited income. Under such a system the physician has been willing to accept a fee somewhat less than he ordinarily charged, but he would have the assurance that this fee would be paid.

The cost of living, taxes, and prices in general have increased during recent years. Wages have increased also. Medical fees have increased somewhat, but I believe it is generally conceded that they have not increased in proportion to other services or commodities. The surgical fee for a common operation such as an appendectomy is not so much more now than it was many years ago.

Surgical benefits and income ceilings should be and have been increased consistent with the development of the plans. A family with an annual income of $4,800 is now entitled to full service benefits under a Wisconsin Physicians' Service provision.

If I sense medical opinion correctly, physicians are still willing and anxious to give the finest medical service to those of limited income at a schedule of fees less than that which is ordinarily charged. I sense also that they are willing to have income ceilings realistically increased, but when incomes reach a point where people can afford to pay for medical service as well as any other service, then physicians do not wish to be bound by a full payment service program.

Any dissatisfaction that exists today may for the most part be obviated by a frank discussion of fees by the physician and the patient before the patient is sent to the hospital. With patients whose incomes are over the full payment limits, I am sure that most of us are willing to keep any additional charge reasonable in proportion to the patient's income.

I realize that there are some illnesses and some procedures that require long, diligent care and may require extraordinary skill. These become expensive and sometimes prohibitive. I believe a catastrophic insurance should be provided to meet this need. Any opinions or constructive criticism in this regard will be appreciated.

J. C. Griffith M.D.

Minutes of the Council Meeting, Hika July 25-26, 1952

1. Call to Order

The Council was called to order by Chairman Arveson at 2:45 p. m., Friday, July 25, 1952, at Rutherford's Lodge, Hika.

2. Roll Call

Councilors present were Doctors Costello, Hemmingsen, Tenney, Kasten, Dessloch, Heidner, McCarey, Bell, Kidder, Arveson, Ekblad, Galasinski, Bernhart, Wegmann, Zellmer, and Chairman Emeritus Gavin.

Also present were President-Elect Griffith; Treasurer Weston; Delegate to the American Medical Association Stovall; Dr. Gunnar Gundersen, Board of Trustees, American Medical Association; Dr. C. N. Neupert, State Health Officer; Mr. Carl Tiffany, consulting actuary, Chicago; Mr. Robert B. Murphy, legal counsel; Secretary Crownhart; Assistant Secretary Ragatz; Mr. Thomas J. Doran, director of the Veterans Agency; Mr. Byron Ostby, Field Secretary; Mr. R. J. Hoops, Comptroller; Miss Joan Pyre and Miss Jean McGruer of the Society's office.

3. Report of the Commission on Prepaid Plans, Second Quarter, 1952.

Dr. E. M. Dessloch, chairman of the Commission, on behalf of the Executive Committee, submitted the following report:

Commission and Committee Meetings

During the second quarter of 1952 the Executive Committee of the Commission met on three occasions, the Claims Committee met seven times, and the Committees on Blue Cross, Research and Development, and Enrollment and Underwriting each held individual meetings, with the full Commission meeting in Madison the evening of June 14, and again on June 15. Thus a total of 14 separate meetings of physicians were held during the second quarter in the administration of the prepaid health care programs of the State Medical Society.

Wisconsin Plan

This report is based on the period of April 1 to June 30, 1952, and in that period of time nine companies have submitted full billing of $500 each as their contribution toward the administration of the program to June 30, 1953. One company, Wisconsin National of Oshkosh, which does not intend to participate under the new specifications, nevertheless recognized that the Society will be confronted with activity on old contracts and submitted a contribution in the amount of $250, which the Commission accepted in behalf of the Society.

Policies of Hardware Mutual and Bankers Life have been approved as complying with the new specifications, and two more are in process of review. Several more are known to be on the way, and some of these represent companies that have not as yet remitted pursuant to the billing.

Councilors and officers are asked to note a staff bulletin to all Wisconsin Plan companies emphasizing the importance of the July 1, 1952, date and various developments in connection with the Wisconsin Plan since the adoption of the new specifications.

Other than maintaining participating physician enrollment and the administration of disputed claims, it is not the current intention of the Commission to engage in any particular promotional effort with reference to the Wisconsin Plan, it being believed that each company should engage in its own promotional effort. However, constant inquiries are directed to the Commission concerning the plan, and for the purpose of general information, it is proposed that a brief descriptive leaflet, somewhat similar to those developed in the past, be prepared later in the year for distribution to those making inquiry.

Insurance carriers participating in the Wisconsin Plan are endeavoring to streamline administrative policies and problems through directing their own inquiries to the American Mutual Insurance Alliance and other trade associations so that in determinations upon the Wisconsin Plan these associations will be a source of distribution of information and assurance of its consistency within the industry.

Participation in the New Plans

The first panel of participating physicians has been prepared and copies have been distributed to all physicians whose names appear in the panel. Solicitation efforts were extensive, and probably no more thoroughgoing solicitation has ever been undertaken. Correspondence arising out of various questions was voluminous, and the solicitation drew requests from various interested groups for staff as well as Commission personnel appearance.

The panel, it will be noted, is effective during the period of July 1 to June 30 each year, but its preparation in the future will be simplified in that only those physicians not recorded as participants will be contacted in the future.

The attention of the Council and officers is directed to the procedure developed for the enrollment of new members of the Society not only in the prepaid programs, but in the open panel program and the Veteran's Medical Service Agency. Through this and other devices it should be possible to prepare the annual panel with considerably less effort in the future.

It may be added that a considerable number of enrollments have been received too late to be in-

cluded in this year's printed panel, and at the request of physicians in stateline locations, such as Dubuque and Menominee, their enrollment has also been accepted.

The State Medical Society numbers in its membership approximately 2,800 physicians in active membership. Many of these physicians, of course, occupy fulltime positions in such fields as public health, administrative activities, insurance organizations, and similar ventures, and are not enrolled in the programs since they are not engaged in serving individual patients as such.

Others whose practice is limited for physical reasons or because of retirement have felt it inappropriate to participate, and it is estimated that taking into consideration these various situations it may be said that the 1952-53 panel, listing approximately 2,000 physicians, represents about an 80 per cent enrollment of those who are engaged in the active practice of medicine in Wisconsin.

The Commission invites the attention of the Council and officers to the fact that the panel represents the first time that there has been publication of the names of those physicians participating in Wisconsin Physicians Service. During the past five years there has been a master list of such participants in the office which could be consulted there, but which was not readily available to physicians and enrolled persons.

W. P. S. and Specific Projects

Claims—Administrative devices in the handling of claims have been considerably revised, and necessarily so because of the complexities arising out of the fact that the Society is now processing claims under old contracts, and the several varieties of them in existence, and is beginning to process claims arising out of contracts written pursuant to the new specifications.

The handling of claims means that each claim must be related to the contract held by the subscriber, and such questions must be determined as:

Is the person covered?
Have the waiting periods and other contract provisions been met?
Were the services rendered covered by the contract?
Which fee schedule applies—the old, the "A" or "B," or contract provisions relating to medical care, anesthesia, radiology, etc.?
What physicians rendered the service? Are they participants?
What is to be done if services were rendered by a participating physician and a nonparticipating physician?
Is payment to be made direct to the physician or to the subscriber?

Beginning July 1, claims were numbered as received and a daily inventory is being kept as claims are processed. Where payment is to be made direct to the physician, IBM cards are now being punched in the headquarters and payment will be made on IBM vouchers for the current month's billing of the physician.

The importance of utilizing IBM equipment cannot be overemphasized. It substitutes mechanical for manual processes. It reduces the factor of error, but more important, provides certain basic records never before maintained in the possession of W. P. S. Statistics can henceforth be more readily prepared and special runs can be made as needed and almost within a matter of hours.

For those who are interested, we have several specimen IBM forms now in use by the State Medical Society, and a brief description of the purpose of each.

The Commission emphasizes that the claim volume has roughly doubled in the last two years, due in part to the plans' growth, in considerable part to the inclusion of home and office surgery, and in part also to greater utilization by the subscriber as his contract becomes older and as he becomes better acquainted with its benefits.

Contract Development—Specimen copies of the group contract, the conversion contract (intended for those who leave groups and continue their coverage on a direct pay basis), and the non-group contract (available to those who purchase as individuals rather than through groups) are provided the Council.

In connection with these several contracts, riders are used to eliminate the waiting period for maternity services where a group meets the underwriting requirements, the elimination of waiting periods for pre-existing conditions where enrollment within the group is in sufficient numbers to justify such procedure, and also specified riders eliminating medical care coverage where only the four-element contract is sold by Blue Cross.

At the present time, Blue Cross, as sales agent, has determined that it desires to sell either the five-element contract in its entirety, or to eliminate from it medical care, making it a four-element contract. The Commission, as of this time, has not instructed Blue Cross otherwise, it apparently being the feeling of the members of the Commission that further time should ensue to determine whether Blue Cross should be instructed to eliminate anesthesia and radiology if the purchaser desires such to be done.

Councilors and officers will recall that an approved specification permits increased benefits over the "A" Schedule to be made available to special classes of employees whose earnings are such that they are beyond the income levels entitled to full payment. Under consideration are proposals to further promote the availability of such benefits.

Sales of New Contracts—On July 1, 1952, sales efforts in the preceding months led to the installation of the "A" Schedule on 633 subscribers, and of the "B" Schedule on 2,170 subscribers, for a total of 2,803; 40 per cent of this total are new enrollees, with 60 per cent being "change-overs" from the old type of coverage; 23 new groups were enrolled

during the prior quarter, effective July 1, with two of the groups containing more than 200 subscribers.

Publicity—The general publicity program is well under way, as each of the councilors and officers must be aware. Advertising has appeared in all daily papers, and plans completed in the second quarter called for future advertising in weeklies, the use of the radio, and the development of promotional literature.

The first newspaper ad resulted in more than 100 inquiries being received in the office the first day following. Individual letters have gone to a number of organized groups throughout the state, and groups already enrolled are being advised of the necessity of converting to the new program as the anniversary date of the old contract arises.

Administration—There are many involved and detailed administrative problems, some of which relate to an individual group, and others constituting a general problem. General regulations for the new W. P. S. changeover program, as they relate to group, conversion, and non-group contracts have been completed.

Research and Development—The problem of the extension of maternity benefits, concisely stated, arises out of the philosophy that where an individual is required to serve a waiting period before maternity benefits are available, there should be extension of these benefits equal to the waiting period when the subscriber is no longer covered by the plan. The reasoning behind this philosophy is that the subscriber has paid a rate based upon the payment of maternity benefits during the time of coverage.

Blue Cross takes the position that since a subscriber having the benefit of maternity coverage under a group contract can take a conversion contract upon retiring from the group, there is no reason for it to engage in the extension of maternity benefits.

The matter is under consideration of the Commissioner of Insurance, who suggests that the insurance industry and the nonprofit plans should handle this problem in the same fashion and justifies that suggestion on the basis that uniformity is in the public interest.

Both Blue Cross and Surgical Care of Milwaukee have indicated opposition to any requirement for the extension of maternity benefits.

Wisconsin Physicians Service, through the Commission on Prepaid Plans, has not yet taken any official position upon the matter, but it should be recalled that the extension of maternity benefits was a requirement of the old Wisconsin Plan, which has been temporarily suspended pending further developments.

In the final analysis, the attitude with reference to this particular matter would seem to be based upon the adequacy of the premium for this coverage, and thus it may be characterized as a rate structure problem. The new contracts being submitted for approval by the Wisconsin Plan companies contain such a provision. Wisconsin Physicians Service does not.

The Society's actuaries, legal counsel, and accountants, together with the administrative staff, plan an early joint conference with the Blue Cross administrative staff, and subsequently it may be anticipated that this will be followed by a joint conference between the Blue Cross and Blue Shield Conference Committees.

Other matters in which studies are now being conducted relate to community enrollment, the payment of benefits for therapeutic x-ray, and similar procedures where provided in lieu of a surgical procedure, diagnostic x-ray, and the possibility of permitting subscribers to secure extension of coverage in period of unemployment through the mechanism of the prepayment of premiums for such eventuality. This latter procedure is comparable in philosophy to waiver of premium under life insurance.

Furthermore, the Commission has instructed its staff to confer with educational authorities over the possibility of creating an annual research fellowship for studies of specific projects in the character of a doctor's thesis.

Immediate efforts are now under way, and will be appropriately reported to the Council in the near future, involving the several subjects of catastrophic coverage, cash benefits concurrent with specified surgical and medical care, and indemnity benefits in the fields of anesthesia, radiology, and medical care, if purchasers of the W. P. S. contract ask for lesser benefits in order to reduce total premium costs.

Under contemplation, but not perfected in any detail at the preparation of this report, is the possibility of creating under the same administrative staff, and under the direction of the Commission, a division to be known as "Physicians Indemnity Plan," which would be the identity under which a general indemnity contract would be written. It must be understood that this subject is involved and deserves detailed and separate consideration by the Council and officers at such time as the Commission itself arrives at a definite recommendation.

These studies have been authorized by the Council and the Commission and the matter is simply being reported to the Council for the purpose of keeping it informed.

At the suggestion of the chairman of the Commission, there are also submitted notes of the staff conference of the State Medical Society held at the end of June in Madison over a two-day period, to review current activities and responsibilities within the staff in direction of the program. The chairman of the Commission suggests that review of these notes will give the councilors and officers a very adequate review of "what's cooking."

Decision must be made in the near future with reference to the experimental program now being conducted in Price-Taylor Counties. The attention of the Council and officers is directed to the item in the staff notes which outlines the suggestion of the staff, not as yet considered by the Commission's Executive Committee.

Conclusion

The Commission on Prepaid Plans meets quarterly, and ordinarily in the month preceding regularly scheduled meetings of the Council. It has instructed the preparation of these quarterly reports through the Executive Committee.

Speaking in behalf of the Commission, it appears that general administration of the program is proceeding smoothly and that conversion to the new program as instructed by the House of Delegates is proceeding in orderly fashion following the initial difficulties caused by the failure of Blue Cross to fully execute its functions as the Society's sales agent.

Councilors and officers will note that because of the development of the new program, the assumption by the Society of some administrative details formerly conducted by Blue Cross, and for other reasons, renegotiation of the agency contract with Blue Cross is anticipated, and as developments come about in this field the Council will be appropriately informed.

There has been as yet no meeting between Blue Cross and Blue Shield at the policy level, but the Executive Committee, following the inevitable apathy that always exists in the warm summer months, hopes to arrange such a conference in the early fall. Some efforts have already been made through correspondence to arrange such a meeting which have not as yet reached any conclusive state as to the character of agenda and time and place of the meeting.

A question is raised at this time concerning information to be made available to the Council in such manner that it may be transmitted to the House of Delegates. The Commission on Prepaid Plans is a committee of the Council and, therefore, reports to the Council. Reports thus far submitted have been in the character of quarterly reports, and it is the suggestion of the Executive Committee that the Council consider directing the preparation of a special report covering activities either through July or August, and referring to financial status as well, which would be submitted to the Interim Committee of the Council, and if approved by that committee, distributed direct to the delegates so that they will have ample opportunity for its review prior to the annual meeting in October.

There was general discussion of the above report and various problems of prepaid insurance by Doctors Costello, Hemmingsen, Tenney, Kasten, Dessloch, Heidner, McCarey, Bell, Kidder, Arveson, Ekblad, Galasinski, Bernhart, Wegmann, Zellmer, Gavin, Griffith, Weston, Stovall, Gundersen, and Neupert.

On motion of Doctors Kasten-Kidder, carried, the report of the Commission was approved, including the proposal that a special report be prepared to date for submission to the Interim Committee, and if approved, to the House of Delegates.

4. Interim Committee Report

A. *Combining Committees*—For some time it has become increasingly apparent that the committee structure of the Society is not in all cases designed for greatest efficiency or most desirable results. Some committees remain in existence long after their functions have been modified, or where the need for them no longer exists.

Where a committee is established by the Society by-laws, it is very difficult to change its functions or to terminate it because of the continuing appointments made by successive presidents. There are also types of committee work within the Society which might better be done through integration of structure and effort.

It is therefore suggested that the Council recommend to the House of Delegates that there be created, under Council direction, a Council on State Departments. This would be made up of six subcommittees which would meet from time to time to determine general policy and to so arrange their affairs as not to overlap or duplicate needlessly. Such a council would organize its own subcommittees and would serve the several fields of state health activities in public health, public welfare, and public instruction.

On motion of Doctors Dessloch-Zellmer, approval was given to the recommendation of the Interim Committee that the Council recommend to the House of Delegates the abolition of certain standing committees, and the creation of a Council on State Departments, with its duties and functions assigned to the Council.

B. *Interim Committee-Executive Committee*—As a matter of information, the secretary has recommended that the Council consider changing the Interim Committee to an Executive Committee as permitted by the Wisconsin corporation statutes. This would not materially change the methods of operation of the Committee, although it would clarify its legal status, something which is believed desirable because of the increasing complexity of Society affairs.

The Committee has authorized the secretary to study the matter further and to make a detailed report at a later date.

The authorization for such study was approved on motion of the Council.

C. *State Medical Society Building Program*—At various meetings of the Interim Committee during the past year, the secretary has discussed with the committee the necessity of planning and action in the matter of increasing the size of Society facilities. When the present house was acquired three years ago, the Society did not contemplate the removal from Milwaukee to Madison of the WPS claims and other staffs. This was directed by the Council in the summer of 1950, with the consequence that more than 25 persons are now located in the Society building in administration of the WPS plan. This number must inevitably increase as the plan continues to grow. Substantially twice

as many claims are being processed as two years ago.

The staff, acting on instructions of the Interim Committee, has retained a specialist in commercial properties to see what land or buildings might be available to the Society at the present time. The consultant, after careful survey, has reported that he is unable to find any building available in Madison at the present time to which the Society offices could be moved, other, possibly, than ordinary office space. There is unimproved land available in various parts of the city. The Society staff reported various options available and advisors consulted relative to the problem and stated that the situation is in sufficient flux so that the Interim Committee should be granted broad powers to make final decisions relating to acquisitions of the property. These should include the authority to retain architects for the purpose of making studies of the type of structure which might be feasible and its estimated cost. All such findings will, of course, be reported back to the Council for final determination.

On motion of Doctors Dessloch-Bernhart, carried, the Interim Committee was granted broad powers to make such final decisions relating to acquisition of property, including the authority to retain architects, and to report back to the Council for final determination.

5. Report of Committee on Military Medical Service and Activities of the Wisconsin Advisory Committee to Selective Service.

The following is the summary of classifications of physicians as of June 30, 1952:

Classification:	*Priority*			
	I	II	III	IV
Total number of registrants	237	49	638	919
1-A (available)	29	13	–	–
1-C (known to be on active duty)	76	7	–	–
1-D (reservists ready to be called)	36	5	–	–
2-A (Local Board and/or Advisory Committee considers essential)	48	16	–	–
3-A (deferred for dependency reasons)	3	3	–	–
4-A (sole surviving son)	1	–	–	–
4-F (deferred for physical reasons)	44	5	–	–

To date, the Advisory Committee has made recommendations, with the advice and assistance of the councilors, on 286 physicians in Priorities I and II under Selective Service. This week the committee begins processing 638 physicians in Priority III in preparation for their possible call-up this fall and winter.

In addition, the Advisory Committee has made recommendations on nearly 400 Army, Navy, and Air Force reserve officer physicians.

Further, the Advisory Committee has processed through the central records office at the State Medical Society and under the direction of the appropriate professional advisory committees, a total of 110 dentists and 64 veterinarians. Starting this week, 420 dentists in Priority III are to be processed through this committee.

Priority III physicians are those who did not have training at government expense and who have had no active service in the Army, Navy, Air Force, Marine Corps, Coast Guard or Public Health Service subsequent to September 16, 1940.

It is believed that most available Priority I physicians will be exhausted by September or October. At that time, both Selective Service and the Reserves will begin calling Priority II physicians. Since there are only a few physicians in this Priority, they will be exhausted within a few months, and the calling of Priority III physicians will come immediately afterward.

Following presentation of this report there was discussion by those present of the various problems encountered by them, with Doctor Weston urging councilors and officers to carefully review the manpower resources in their districts, so that recommendations would be realistic as to the needs of the community and of the Armed Forces.

Doctor Arveson thanked Doctor Weston on behalf of the councilors and officers and commended the report.

6. Further Report of Interim Committee

The Interim Committee reported its joint study with other committees of the Society as to the feasibility of developing as a medical shrine the restored portion of the Fort Crawford Military Hospital at Prairie du Chien, the development of a special feature article in the January, 1953, issue of the Wisconsin Medical Journal on "Who's Who in the Health Field in Wisconsin," the location of the Wisconsin Continuation Center, and presented the following matters for Council action:

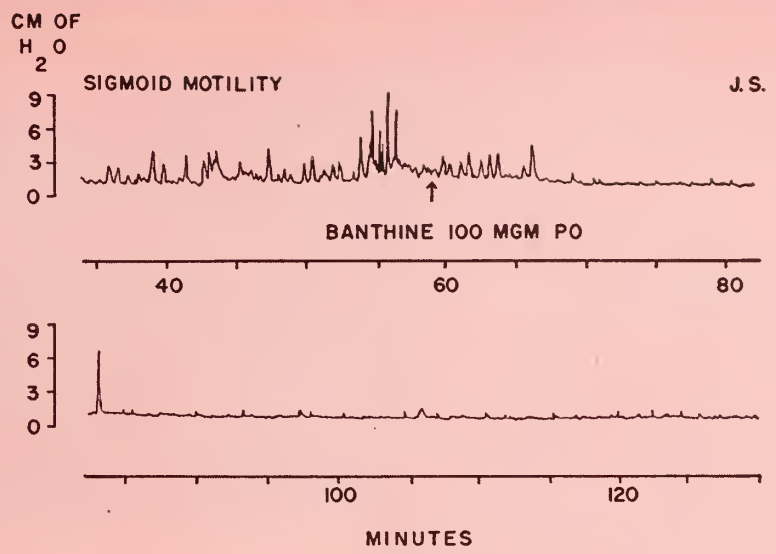
Amendment of By-Laws Relating to Quorum of the House of Delegates—The Interim Committee reported that the by-laws specify that the quorum of the House shall constitute one-fourth of its members, and pointed out that many state medical associations include an additional requirement that such quorum represent a specified number of the county medical societies in the state, so as to assure geographic representation in the quorum.

On motion of the Council, it instructed the inclusion of a recommendation for the amendment of the by-laws and the report submitted to the House of Delegates by the Council.

Section Delegates—The Interim Committee reported that several matters had been presented to it for advice to the secretary's office relative to the matter of section delegates. In several instances, delegates selected to represent a section had, in actual fact, been elected at a meeting of a specialty society. In another case, the section desired more than one delegate.

The Interim Committee felt that the entire matter of section delegates should be reviewed, and on motion of Doctors Dessloch-Kasten, carried, the chairman was authorized to appoint a special committee to report its recommendations at the September meeting of the Council.

Physicians Appointed to Blue Cross Membership—In accordance with section 180.32 of the Statutes of



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1. Kern, F., Jr.; Almy, T. P., and Stolk, N. J.: Effects of Certain Antispasmodic Drugs on the Intact Human Colon, with Special Reference to Banthine (β-Diethylaminoethyl Xanthene-9-Carboxylate Methobromide), Am. J. Med. *11*:67 (July) 1951.

2. Lepore, M. J.; Golden, R., and Flood, C. A.: Oral Banthine, an Effective Depressor of Gastrointestinal Motility, Gastroenterology *17*:551 (April) 1951.

RESEARCH IN THE SERVICE OF MEDICINE **SEARLE**

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Wisconsin, under which Associated Hospital Service Inc. operates, the physicians and surgeons who are appointed to membership in that organization are subject to the approval of the State Medical Society of Wisconsin. The following physician members have been appointed since the last approval was given in 1951:

R. F. Schoen, Beaver Dam
A. W. Hilker, Eau Claire
H. E. Cook, Milwaukee
D. M. Willson, Milwaukee
G. F. Kelly, Milwaukee
A. D. Kilian, Milwaukee
Edward Eisenberg, Milwaukee
W. J. Fencil, Monroe
R. E. Schrank, Waupun

The Interim Committee recommended that such physicians be approved, and on motion of Doctors Kasten-Bernhart, carried, the Council approved these appointments and directed the secretary to so inform Associated Hospital Service Inc.

7. Round Table Discussion

At the May meeting it had been suggested that the agenda of the Council be so arranged as to provide an open period during which members of the Council, officers, and guests might be provided detailed information concerning Society policy and administration, and the secretary presented Mr. Ragatz, Assistant Secretary, and Mr. Hoops, Comptroller, who discussed activities under their direction and answered questions concerning them.

On motion of Doctors Dessloch-Bell, each of the staff members was complimented on the thoroughness of his report and on the care with which he administered Society activities.

8. Executive Session

On request of the chairman the Council entered into executive session, without recording its discussion and with no action taken.

9. Adjournment

The meeting adjourned at 12:30 p.m., Saturday, July 26, 1952.

C. H. Crownhart
Secretary

Approved:

R. G. Arveson, M.D.
Chairman of the Council

THE AMERICAN DERMATOLOGICAL ASSOCIATION ANNUAL PRIZE ESSAY CONTEST

The American Dermatological Association is again offering a prize of $300 for the best essay submitted for original work, not previously published, relative to some fundamental aspect of dermatology or syphilology. The purpose of this contest is to stimulate investigators to original work in these fields.

Manuscripts typed in English with double spacing and ample margins as for publication, together with illustrations, charts, and tables, all of which must be in *triplicate*, are to be submitted not later than January 1, 1953. The manuscripts should be sent to Dr. Louis A. Brunsting, Secretary, American Dermatological Association, 102–110 Second Avenue, Southwest, Rochester, Minnesota. Those which are incomplete in any of the above respects will not be considered.

Competition in this prize contest is open to scientists generally, not necessarily to physicians.

The award will be made by a committee of judges selected to pass on the essays by the Research Aid Committee of the American Dermatological Association and the decision of the judges shall be final. The essays are judged on the following considerations: (1) originality of ideas; (2) potential importance of the work; (3) experimental methods and use of controls; (4) evaluation of results; (5) clarity of presentation. This contest is planned as an annual one, but if in any year, at the discretion of the Committee and judges, no paper worthy of a prize is offered, the award may be omitted.

The prize winning candidate may be invited to present his paper before the annual meeting of the American Dermatological Association with expenses paid in addition to the $300 prize. Further information regarding this essay contest may be obtained by writing to the Secretary of the American Dermatological Association.

The next annual meeting of the American Dermatological Association will be held June 9–13, 1953, at The Lake Placid Club, Essex County, New York.

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RECENT WISCONSIN LICENTIATES

At a meeting held in Oshkosh, March 25–27, the following physicians were granted licenses by the State Board of Medical Examiners.

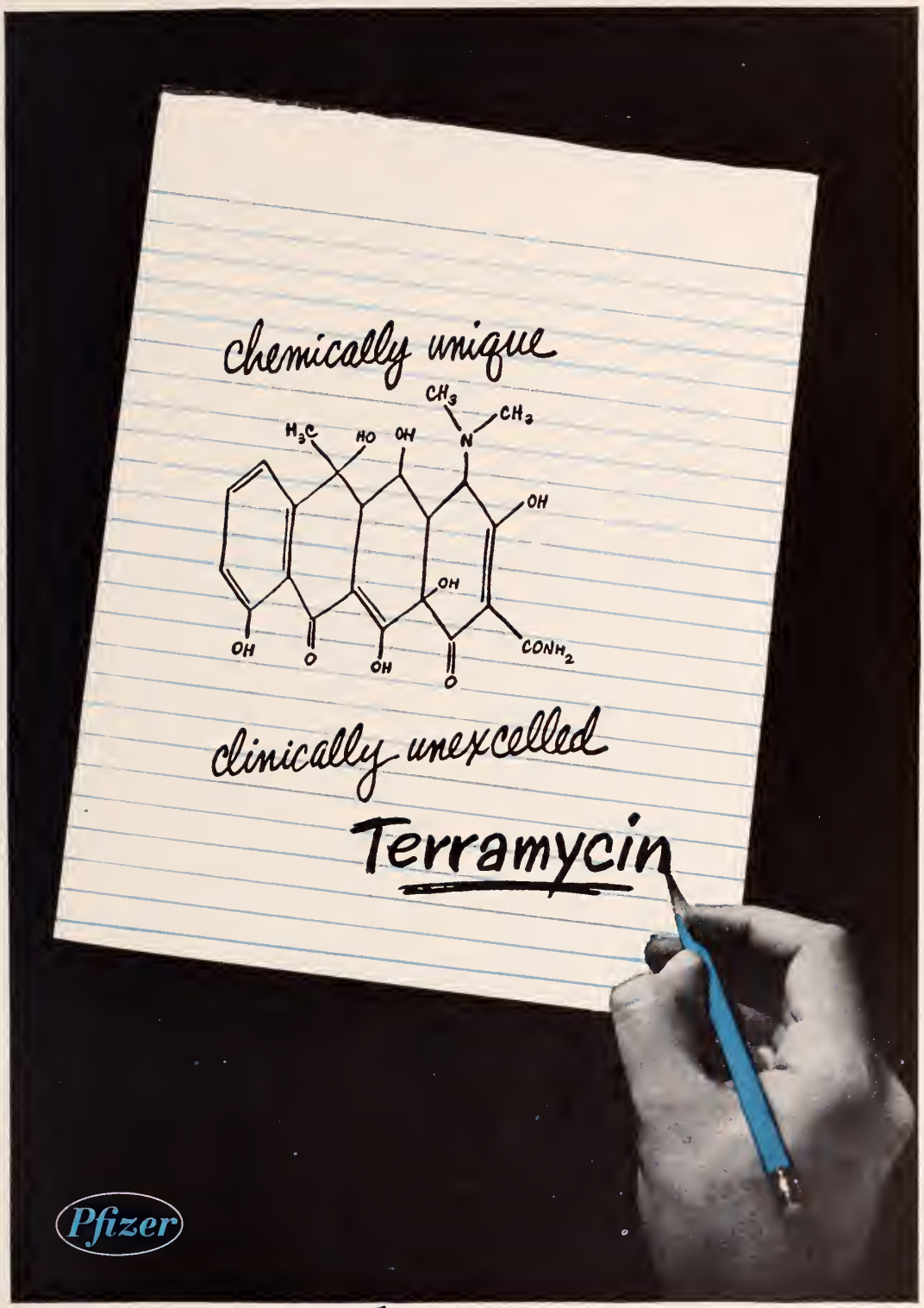
Name	*School of Graduation*	*Year*	*Address*
Bryan, C. G.	Iowa	1950	444 N. Charter, Madison
Jaffee, M. L.	Chicago	1951	Korbol Building, Nekoosa
Peterson, D. A.	Northwestern	1950	7 N. Henry, Madison
Schwerma, Kathryn B.	Wisconsin	1946	Lake View Sanatorium, Madison
Shearer, T. M.	Northwestern	1951	Edgerton

The following physicians were granted licenses by reciprocity by the State Board of Medical Examiners following examinations at Oshkosh, March 27.

Name	*School of Graduation*	*Year*	*Address*
Ascher, D. S.	Tufts	1938	Box 6, Patten, Maine
Craychee, W. A.	Temple	1945	712 South Hampton, Fairmont, Minn.
Davis, Milton, Jr.	Louisville	1940	718 Huron Hill, Madison
Docktor, J. P.	George Washington	1943	1625 Undercliff, New York 53
Dornette, W. H.	Cincinnati	1946	Wisconsin General Hospital, Madison
Garritty, J. E.	Long Island	1949	Stahmer Clinic, Wausau
Glesne, O. G.	Iowa	1933	2064 Bennett Street, Dubuque, Ia.
Hackman, Pearl E.	Woman's Medical College	1924	Tower Hotel, Milwaukee
Himes, Joseph	Chicago	1946	1714 Washington, Waukegan, Ill.
Karolus, H. E.	Marquette	1934	Warren, Illinois
Klocker, K. J.	Chicago	1935	Silver Lake
Konrad, M. G.	Louisville	1947	Milwaukee County Hospital, Milwaukee
Kurtin, H. J.	Marquette	1938	Blooming Prairie, Minn.
Kurtin, J. J.	Marquette	1949	Blooming Prairie, Minn.
Lichtenstein, Robert	Northwestern	1950	2521 North Downer Avenue, Milwaukee
McDonald, J. F., Jr.	Creighton	1943	Sacred Heart San., Milwaukee
McMahon, R. E.	Columbia	1938	317 Main Street, La Crosse
Miller, R. L.	St. Louis	1945	2236 15th Street, Cuyahoga Falls, O.
Moser, R. H.	Rush	1922	23 East Ohio Street, Indianapolis, Ind.
Murphy, G. F.	Illinois	1948	5000 West Chambers, Milwaukee
Russell, J. H.	Virginia	1949	Veterans Administration, Wood
Smaller, B. I.	Illinois	1947	5419 South Ingleside, Chicago
Summerville, M. J.	Illinois	1929	333 Forest, Oak Park, Ill.
Winskunas, F. C.	Loyola	1932	7004 South Fairfield, Chicago
Wolford, L. E.	Vanderbilt	1943	Wisconsin General Hospital, Madison

The following physicians were granted licenses by the State Board of Medical Examiners, following examinations at Milwaukee, July 8–10:

Name	*School of Graduation*	*Year*	*Address*
Allen, J. R.	Wisconsin	1951	811 West Dayton, Madison
Ambro, P. J.	Wisconsin	1951	1808 N. 24th, Milwaukee
Appleton, D. M.	Cincinnati	1951	3751A North 50th, Milwaukee
Arendt, C. J.	Wisconsin	1951	Mercy Hospital, Janesville
Baaren, H. J. van	U. of Utrecht, Amsterdam, Holland	1932	426 North Charter, Madison
Barta, R. F.	Marquette	1951	8823 Jackson Boulevard, Wauwatosa
Becker, J. F.	Marquette	1951	3321 North Maryland, Milwaukee
Bennett, R. P.	Wisconsin	1951	109 Lake Street West, Ladysmith
Blose, I. L.	Loyola	1951	1956 West Harrison, Chicago
Bormes, R. E.	Loyola	1951	617 West Madison, Milwaukee
Bower, P. L.	Wisconsin	1951	325 East Newhall, Waukesha
Bremer, E. M.	Wisconsin	1951	19 Craig Avenue, Madison
Brennan, T. V.	Boston	1951	628 North 19th, Milwaukee
Briggs, M. C.	Marquette	1951	Black River Falls
Brown, J. F.	Wisconsin	1951	Mineral Point
Brucker, E. A., Jr.	Loyola	1951	336 North 75th, Milwaukee
Budnick, T. J.	Marquette	1951	1737 North Cambridge, Milwaukee
Casey, J. H.	Marquette	1951	4210 North 45th, Milwaukee
Cassinelli, Erma E.	Marquette	1951	Milwaukee County General Hospital, Milw.
Cherniss, E. I.	Iowa	1951	Milwaukee County Hospital, Milwaukee
Clatanoff, D. V.	Nebraska	1951	13 Sherman Terrace, Madison
Cornfield, J. R.	Wisconsin	1951	2671 North Grant B., Milwaukee
Crowley, P. J.	Loyola	1951	7650 South Prairie, Chicago
Cusick, W. S.	Loyola	1951	Bloomington
Daley, E. F.	St. Louis	1951	1327 Eliza, Green Bay
Dehorn, W. H.	Marquette	1951	4904 W. Bluemound Road, Milwaukee
Devitt, J. J., Jr.	Marquette	1951	7515 W. Beloit, West Allis



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Name	School of Graduation	Year	Address
Dudenhoefer, P. A.	Marquette	1951	8920 West Bluemound Road, Milwaukee
Durst, J. B.	Marquette	1951	4235 North 44th, Milwaukee
Eisenbraun, J. M.	Wisconsin	1951	117 Van Duesen, Madison
Ellenz, G. B.	Loyola	1951	1020 Bowman Street, Wisconsin Dells
Engbring, N. H.	Marquette	1951	6110 West Lisbon, Milwaukee
Erwin, C. P.	Oklahoma	1951	Tower Hotel, Milwaukee
Erwin, Constance R.	Oklahoma	1951	Tower Hotel, Milwaukee
Fausnaugh, C. L.	Pennsylvania	1951	University Hospital, Iowa City, Iowa
Ferguson, E. C.	Marquette	1951	204 E. Grand Ave., Eau Claire
Ferguson, S. H.	Wisconsin	1951	New Lisbon
Fransway, R. L.	Wisconsin	1951	Rt. 14, Box 522, Milwaukee
Frederick, J. J.	Marquette	1951	4449 South Packard, Cudahy
Froeschle, R. P.	Illinois	1951	Sparta Clinic, Sparta
Gardner, R. J.	Northwestern	1951	Menomonie
Getz, Kaare	U. of Oslo	1950	1910 South Avenue, La Crosse
Giles, L. T.	Wisconsin	1951	1001 Femrite Drive, Madison
Grant, Rita F.	Wisconsin	1951	3118 North 50th, Milwaukee
Gredler, G. P.	Wisconsin	1951	305 Court Street, Janesville
Hadley, J. O.	Illinois	1951	706 Madison Street, Watertown
Handa, Yoshio	Creighton	1951	St. Mary's Hospital, Madison
Harkavy, Leo	Wisconsin	1951	3861 North 53rd, Milwaukee
Helme, W. B.	Chicago	1951	6625 Vista Avenue, Milwaukee
Henney, T. E.	Wisconsin	1951	216 East Franklin, Portage
Herlitzka, A. J.	Wisconsin	1951	1613 West Avenue South, La Crosse
Hilrich, Nathan	Wisconsin	1951	2750 N. 50th Street, Milwaukee
Hogle, G. S.	Cincinnati	1951	2109 Rowley Avenue, Madison
Huckaby, A. S.	Wisconsin	1951	5650 N. River Forest Dr., Milwaukee
Ibach, H. F.	Wisconsin	1951	1308 East 49th, Kansas City, Mo.
Kilpatrick, L. G.	U. Oxford, England	1944	Wisconsin General Hospital, Madison
Ives, D. G.	Marquette	1951	825 South 1st St., Ann Arbor, Mich.
Konicek, R. G.	Marquette	1951	405 S. Ohio St., Prairie du Chien
Kopp, W. J.	Cincinnati	1950	721 N. 17th Street, Milwaukee
Kronschnabel, E. F.	Marquette	1951	Menasha
Kuhl, H. L.	Illinois	1950	6621 W. Bluemound Road, Milwaukee
Lakritz, Amrum	Marquette	1951	3152 N. 44th Street, Milwaukee
Landmann, G. A.	Marquette	1951	183 East Fairmount, Milwaukee
Lende, R. A.	Oregon	1951	Wisconsin General Hospital, Madison
Lerner, G. E.	Wisconsin	1951	2742 North Avondale, Milwaukee
LeTellier, R. P.	Marquette	1951	2538 N. 45th St., Milwaukee
Linn, J. C.	Marquette	1951	4208 N. 44th St., Milwaukee
Looze, J. P.	Marquette	1949	Veterans Administration Hosp., Wood
Luther, T. W.	Wisconsin	1950	1754 S. 62nd Street, West Allis
Magnuson, C. W.	Illinois	1951	8700 West Wisconsin, Milwaukee
Malloy, P. J.	Marquette	1951	2565 North Grant, Milwaukee
McCormick, R. A.	Marquette	1951	3800 N. Oakland, Milwaukee
Moore, J. N.	Cincinnati	1951	20 Sherman Terrace, Madison
Nilles, J. E.	Marquette	1951	1418 18th St., Two Rivers
Olson, L. L.	Wisconsin	1951	Monroe Clinic, Monroe
Perlson, S. G.	Wisconsin	1951	4119 North 16th, Milwaukee
Pfeiffer, L. R.	Wisconsin	1951	Cumberland
Prentice, B. C.	Minnesota	1952	522 West Second, Ashland
Price, J. M.	Wisconsin	1951	1615 Hoyt Street, Madison
Ratelle, A. E.	Minnesota	1952	Sturgeon Bay
Rath, E. K.	Marquette	1951	New Glarus
Reik, R. P.	Marquette	1951	2920 N. 56th, Milwaukee
Richardson, R. J.	Marquette	1951	4131 North 14th, Milwaukee
Rosenheimer, L. M.	Marquette	1951	3162 South 26th, Milwaukee
Rowe, D. M.	Marquette	1951	535 North 32nd Street, Milwaukee
St. Ville, J. McK.	Marquette	1951	303 North Jackson, Elkhorn
Samp, R. J.	Wisconsin	1951	2229 Eton Ridge, Madison
Savino, P. R.	Marquette	1950	836 N. 24th, Milwaukee
Schaller, J. W.	Illinois	1951	132 N. Brainar, La Grange, Ill.
Schloesser, L. L.	Kansas	1951	325 N. Lake, Madison
Schmidt, D. K.	Marquette	1951	2805 N. 69th, Milwaukee
Schwartz, Ruth E.	Wisconsin	1950	Genesse Hospital, Rochester, N.Y.
Shapiro, W. D.	Wisconsin	1951	880 S. Cleveland, St. Paul, Minn.
Shields, C. H., Jr.	Cincinnati	1951	1125 Grant Street, Fennimore
Slamer, J. R.	Marquette	1950	3465 N. P. Wash. Ave., Milwaukee
Smart, S. I.	Illinois	1951	2106 S. 85th St., Milwaukee
Smiley, G. A.	Marquette	1951	4472 W. Hope, Milwaukee
Smith, B. K.	Wisconsin	1951	502 3rd St., Wausau
Smith, L. W.	Marquette	1946	2925 Wash. Ave., Racine
Smith, R. L.	Wisconsin	1951	914–A N. 16th, Milwaukee
Smythe, L. J.	Wisconsin	1951	928 University Bay, Madison
Sosman, Abe	Wisconsin	1951	2630 North Humboldt, Milwaukee
Stokdyk, G. A.	Marquette	1951	230 West Madison, Milwaukee

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No. 410-10. DeLee, standard, length 14 inches.

No. 410-125. Hawks-Dennen, with traction curve, length 15½ inches.

No. 410-65. Barton, length 14 inches.

No. 410-70. Barton Traction Handle, (not illustrated).

No. 410-75. Kieland, length 15½ inches.

No. 410-80. Luikart, length 15½ inches.

No. 410-90. McLean, blades modified by Luikart, length 14 inches.

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Name	*School of Graduation*	*Year*	*Address*
Sydow, W. O.	Marquette	1951	4269 N. 44th, Milwaukee
Thimke, H. E.	Wisconsin	1951	148 Main St., Shawano
Thomas, Lillian M.	Marquette	1951	519 W. Mitchell, Milwaukee
Thompson, J. E.	Wisconsin	1951	Blanchardville
Toussaint, J. B.	Wisconsin	1951	U. of Wis. Hospital, Madison
Tuchman, Herman	Wisconsin	1951	Univ. of Wisconsin, Madison
Ullrich, D. P.	Marquette	1951	1025 N. 21st Street, Milwaukee
Vig, D. E.	Wisconsin	1951	110 W. South Street, Viroqua
Vig, DeVerne, W.	Wisconsin	1951	110 W. South Street, Viroqua
Vrabec, A. P.	Wisconsin	1951	111 Sloan Circle, Beaver Dam
Weston, C. L.	Wisconsin	1951	New Lisbon
Zupnik, G. R.	Marquette	1951	2803 N. 11th St., Milwaukee

At the July 9 meeting of the State Board of Medical Examiners, the following physicians were granted licenses by reciprocity:

Name	*School of Graduation*	*Year*	*Address*
Baker, R. L.	Minnesota	1935	Wisconsin General Hospital, Madison
Bjork, H. A.	North Dakota and Rush	1941	625 57th Street, Kenosha
Braga, Gennaro F.	Marquette	1946	1758 61st Street, Brooklyn, N.Y.
Burr, T. C., Jr.	Indiana	1950	506 Third Street, Wausau
Cauldwell, E. W.	Northwestern	1944	610 Oakton Street, Evanston, Ill.
Coyne, J. F., Jr.	Pennsylvania	1949	902 Seymour Avenue, Lansing, Mich.
Estrada-Molinari, I.	Marquette	1942	Mt. Sinai Hospital, Milwaukee
Flinn, J. H.	Northwestern	1941	221 Chestnut Street, Evansville, Ind.
Gunderson, S. B., Jr.	Harvard	1948	504 Keith Avenue, Waukegan, Ill.
Hale, W. H.	Northwestern	1950	214 N. Superior St., Appleton
Heighway, T. F.	Northwestern	1947	2101 Mayflower Drive, Middleton
Hirsh, E. I.	Chicago	1942	3638 W. Polk Street, Chicago 24
Huston, J. H.	Northwestern	1944	1824 Church Street, Wauwatosa
Johnson, E. H.	Wisconsin	1949	3925 Hammersley Ave., Madison
Lalich, J. J.	Wisconsin	1937	426 North Charter St., Madison
Levens, A. J.	Wisconsin	1943	309 W. Franklin St., Portage
Linsley, L. E.	Loyola	1945	Box 999, Santa Rita, N. M.
Longo, D. V.	Tulane	1926	2112 Tulane Avenue, New Orleans, La.
Mace, N. C.	Oregon	1929	Veterans Hospital, Tomah
Magner, J. P.	Vermont	1940	Schiek Clinic, Rhinelander
Mahaffey, H. W.	Ohio	1942	16 South Henry St., Madison
March, J. F.	Washington	1950	413 Fourth Street, Algoma
Maryan, H. O.	Illinois	1924	674 Irving Park Road, Chicago
McCann, J. P.	Iowa	1941	230 North 22nd St., La Crosse
McLane, H. J.	Yale	1946	80 Sheboygan St., Fond du Lac
Nesbitt, R. J.	Illinois	1945	1516 S. Albany, Chicago
O'Neill, P. B.	Pittsburgh	1941	720 N. Jefferson, Milwaukee
Pauly, J. P.	Iowa	1944	La Crosse Clinic, La Crosse
Pellicore, R. J.	Loyola	1943	1930 E. Locust St., Milwaukee
Perry, T. K.	Illinois	1946	4330 Bagley Parkway, Madison
Pond, N. E.	Minnesota	1950	Milwaukee County Hospital, Milwaukee
Potts, Thelma H.	Ohio	1931	1222 South 35th St., Milwaukee
Reeck, L. K.	Iowa	1944	4223 Winnequah Road, Madison
Ruchie, W. H.	St. Louis	1946	1765 East Ave., St. Paul 9, Minn.
Schnell, F. S.	Marquette	1950	1216 8th Ave. N., Virginia, Minn.
Smith, N. D.	Oregon	1949	2309 South 90th St., Milwaukee
Willoughby, William	Colorado	1949	1110 Hamilton Boulevard, Peoria, Ill.
Wingett, W. T.	Nebraska	1939	Sacred Heart San., Milwaukee
Wright, F., Jr.	Illinois	1950	416 Watson Street, Ripon

CHICAGO MEDICAL SOCIETY TO HOLD CLINICAL CONFERENCE MARCH 3–6

March 3, 1953, will mark the opening day of the four day annual Clinical Conference of the Chicago Medical Society. This conference is designed to be of interest to both the specialist and the general practitioner. It will be held at the Palmer House in Chicago and will present a variety of subjects setting forth the latest information available to the medical profession.

Conducting the conference will be a faculty ranging from 35 to 40 outstanding speakers, each offering a presentation relating to his specialty. In addition another group will give daily teaching demonstrations which will include the presentation of patients. They will emphasize the actual technic to be employed in handling orthopedic, medical, and pediatric problems. In addition to holding these demonstrations each day, there will be a panel discussion at a round table luncheon presenting topics of timely interest.

This is an activity of the Chicago Medical Society for its membership to whom no fee is charged. Those who are not members of the Chicago Medical Society are asked to register for the four days at the fee of $5.00. For further details, write to the Chicago Medical Society, 30 North Michigan Avenue, Chicago 2, Illinois.

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Society Proceedings

Brown–Kewaunee–Door

The Brown–Kewaunee–Door County Medical Society met in Green Bay at the Elks Lodge on October 9. The scientific program, arranged by *Dr. P. F. Dockry*, Green Bay, featured a talk by *Dr. Joseph Shaiken*, who is an assistant clinical professor of medicine at Marquette University School of Medicine. Doctor Shaiken chose "Progress in Medical Treatment of Peptic Ulcer" as his subject.

During the business meeting final arrangements were made for the Society to sponsor a year's stay in Green Bay for a high school boy from Istanbul, Turkey. More details on this will be found in the Medical Forum section of this issue of the Journal.

Douglas

A business meeting was held by the Douglas County Medical Society at the Hotel Superior on October 1. The first order of business was the election of officers for 1953. *Dr. F. G. Johnson, Jr.*, will be the new president, *Dr. R. T. Anderson*, vice-president, and *Dr. F. W. Reibold*, secretary-treasurer. All of the officers are from Superior. The Society also approved and presented a new fee schedule to the city and county welfare boards.

Outagamie

The Riverview Sanatorium in Kaukauna was the meeting place on October 16 of the Outagamie County Medical Society. *Dr. Fred O. Kuehl* of Green Bay, a specialist in allergies, was the guest speaker. He discussed the diagnosis and treatment of bronchial asthma.

Richland

Dr. Sture A. M. Johnson, Madison, was the guest speaker at the September 2 meeting of the Richland County Medical Society held at the Richland Hospital. Doctor Johnson, who is a professor of dermatology at the University of Wisconsin Medical School, presented a paper entitled "Eruptions of the Hands and Feet."

Winnebago

Meeting on October 2 at the Columbus Club, the members of the Winnebago County Medical Society heard an address by Dr. Walter Zeit of Milwaukee. Doctor Zeit who is professor and director of the department of anatomy, Marquette University School of Medicine, chose "The Autonomic Nervous System" as the subject of his talk. A dinner preceded the scientific program.

Wisconsin Society of Obstetrics and Gynecology

The fall meeting of the Wisconsin Society of Obstetrics and Gynecology was held on October 11 at the Hotel Loraine in Madison. The speakers during the morning program were as follows: *C. A. Hultman*, Milwaukee, "Artificial Vagina—Construction Problems;" *J. P. Miller*, Milwaukee, "Bilateral Dermoid Cysts and Pregnancy;" *T. A. Leonard*, Madison, "Wisconsin Maternal Mortality Study Committee;" *J. H. Kamholz*, Madison, "Menopausal and Postmenopausal Bleeding;" *A. H. Stahmer*, Wausau, "Severe Postpartum Eclampsia;" and *G. C. Hank*, Madison, *Elizabeth A. Steffen*, Racine, and *T. J. Rice*, Marshfield, "A Symposium on Toxemias of Pregnancy."

Following luncheon, Dr. A. Herbert Marbach, clinical professor of gynecology at Hahnemann Medical School, presented a paper entitled "Pain, A Gynecological Symptom."

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News Items and Personals

Viroqua Hospital Adds New Doctors

Two new physicians have joined the staff at the Vernon Memorial Hospital in Viroqua. *Dr. Edward Vig* and *Dr. De Verne Vig* have recently become associated with *Dr. Lars Gulbrandsen*. Both of the brothers are graduates of the University of Wisconsin Medical School. Until recently Dr. Edward was a resident at Madison General Hospital, and Dr. De Verne completed his internship in a Virginia hospital a short time ago.

Wisconsin Surgeons Honored

Among the Wisconsin surgeons who were recently honored by election to fellowship in the American College of Surgeons are *Drs. N. O. Becker* and *F. J. Cerny*, Fond du Lac; *J. R. Hoon*, Sheboygan; and *J. V. Bolger, Jr.*, Waukesha. The Wisconsin men were among the 1,100 surgeons who received their fellowships at the close of the September meeting of the college in New York City.

Fellowship, entitling the recipient to the designation "F.A.C.S." following his name, is awarded to doctors who fulfill specific requirements for acceptable medical education and advanced training as a specialist in one of the branches of surgery, and who give evidence of good moral character and ethical practice.

Fennimore Has New Physician

Early in September Dr. Charles H. Shields, who recently completed internship at St. Mary's Hospital, Madison, established his practice in Fennimore. The doctor is a graduate of the University of Cincinnati College of Medicine. A veteran of World War II, he served three year in the army as a laboratory technician, including two years of duty overseas.

Doctor Pease Feted on His 50th Anniversary

The Rio Community Club sponsored a get-together on October 9 to pay tribute to *Dr. W. A. Pease* on the occasion of his fiftieth anniversary as a physician in Rio and the surrounding area. In addition to his friends and patients, many of the doctor's colleagues were present to honor him. *Dr. J. W. MacGregor*, Portage, served as toastmaster and *Dr. C. W. Henney*, also of Portage, was the main speaker. Among those seated at the speakers table with Doctor Pease were *Drs. R. H. Jackson*, and *G. H. Ewell*, Madison; *J. A. Mudroch*, Columbus; and *W. C. Maas*, Rio.

Dr. H. E. Schaefer Enlists in Air Force

Dr. H. E. Schaefer, Manitowoc physician and former superintendent and medical director of the Maple Crest Sanatorium, Whitelaw, joined the Army Air Force last August. Captain Shaefer is now on duty at the Gunter Air Base at Montgomery, Alabama.

Doctor Milson Honored at Chicago Meeting

Dr. Louis Milson of Green Bay was made a Fellow of the International College of Surgeons on September 5 at the College's annual meeting held in Chicago. The doctor has practiced medicine and surgery in Green Bay for the past 27 years. He received his M. D. degree at Marquette University School of Medicine and has also done postgraduate work at Harvard University and the University of Vienna.

THIRD AND TWELFTH DISTRICT NEWS

"Doc Treadwell Day" Held at Friendship

Friends, neighbors, and patients of *Dr. Glenn F. Treadwell* attended a testimonial program for him on September 6 at the Adams County Fairgrounds. About 850 people, including 150 of the 2,500 babies the doctor has delivered, were present to hear the doctor praised for his 40 years of service to the people in the surrounding area. The doctor was presented with an inscribed gold watch and a gift of money from his friends. Mrs. Treadwell was given a table radio.

U. W. Offers Unusual Course

"Problems in the Biology of Infectious Disease" is a formal course being offered during the fall semester 1952 at the University of Wisconsin by Knapp Visiting Professor, Sir Frank M. Burnet, M. D., Ph.D., director of the Walter and Eliza Hall Institute for Medical Research, Melbourne, Australia and professor of experimental medicine, University of Melbourne.

Doctor Burnet will present three afternoon lectures a week from October 13 to 19 and November 3 to 30. University students may take the course for one credit or audit it, and the lectures also will be open to University staff members and guests.

Adams Physician to Take Post-graduate Work

Early in October, *Dr. B. P. Ingersoll*, Adams, began a one year residency at the Matty Hersee Hospital in Meridian, Mississippi. The doctor had practiced in Plainfield prior to moving to Adams 10 years ago. He is a graduate of the College of Medical Evangelists, Los Angeles. During his absence, his father, *Dr. R. S. Ingersoll* will be in charge of the Adams–Friendship Hospital.

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Operating Room in Hospital	10.00	20.00	30.00	40.00
Anesthetic in Hospital	10.00	20.00	30.00	40.00
X-Ray in Hospital	10.00	20.00	30.00	40.00
Medicines in Hospital	10.00	20.00	30.00	40.00
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Testimonial Dinner Given for Doctor Tatum

On September 10, a dinner honoring *Dr. A. L. Tatum,* chairman of the department of pharmacology at the University of Wisconsin, was given at the Hoffman House, Madison, by colleagues, associates and former students of Doctor Tatum. After brief talks sketching his research interest, the doctor was presented a beautifully illustrated scroll depicting these achievements and signed by all in attendance.

Janesville Has New Orthopedic Surgeon

Dr. P. K. Odland, who recently completed three years of training in orthopedic surgery at Wood Hospital and Milwaukee Children's Hospital, has become associated with *Dr. G. L. Thomas* in Janesville. A graduate of Temple University School of Medicine, Philadelphia, Doctor Odland plans to specialize in children's orthopedics.

Doctor Talbot Opens Madison Office

Dr. John R. Talbot, who has been in residency at Wisconsin General Hospital since January of 1950, has opened offices for private practice in Madison. In addition he has received a teaching assignment as assistant clinical professor of medicine at the University of Wisconsin Medical School. Prior to beginning his residency, the doctor practiced at Wonewoc for four years.

Madison Urologist Elected to Fellowship

Dr. A. P. Schoenenberger, Madison urologist, was awarded a fellowship in the American College of Surgeons at a meeting of the College in New York City late in September. The doctor served his residency at Wisconsin General Hospital, following his discharge from service after World War II.

Rock

The Rock County Medical Society met at the Beloit Country Club in Beloit on September 23. A dinner with the auxiliary preceded the scientific program. The guest speaker was Dr. L. R. Limarzi, who is on the staff of the University of Illinois College of Medicine. Doctor Limarzi chose "Applied Hematology" as the subject of his talk.

Sauk

The members of the Sauk County Medical Society met in Baraboo at the Hotel Warren on October 14. There was no formal program planned, but *Dr. J. F. Moon,* Baraboo delegate from Sauk County to the House of Delegates of the State Medical Society, reported on the actions taken by the House at its recent meeting in Milwaukee.

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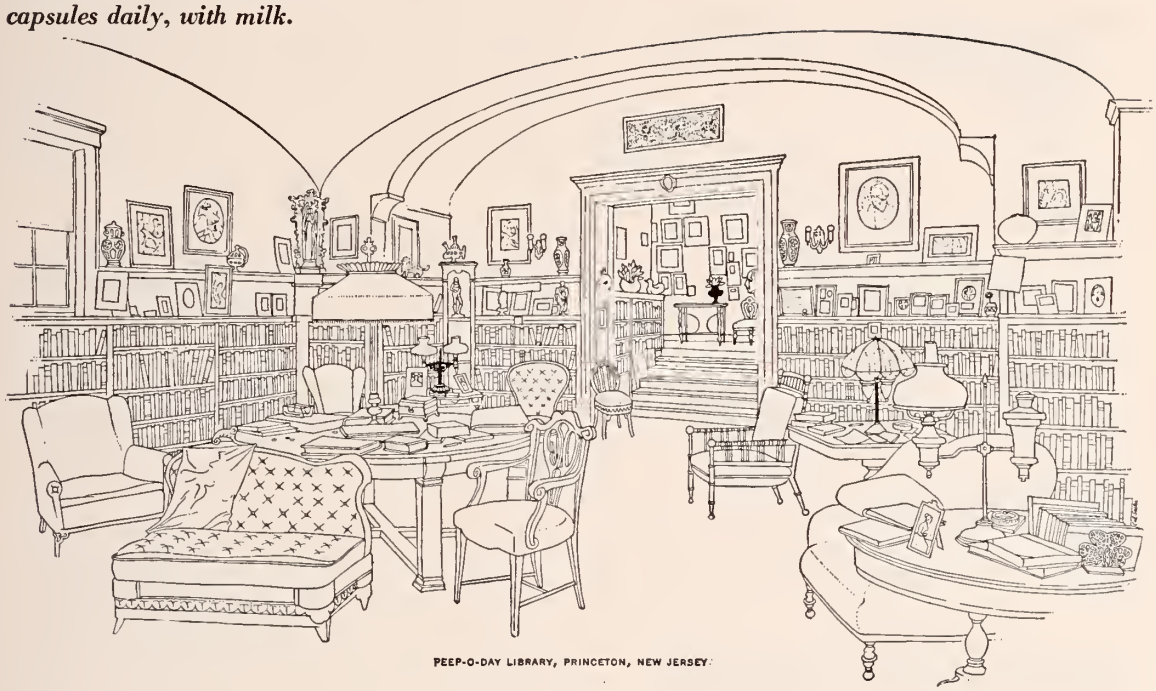

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Doctor Welsh Receives New Post

The appointment of *Dr. E. C. Welsh* as director of Columbia Hospital's department of physical medicine and rehabilitation was recently announced. The doctor is a clinical instructor in physical medicine and rehabilitation at Marquette University and will also continue his work at the Veterans Administration Center, Wood, where he has served as assistant chief in his specialty.

Doctor Arnold Moves to Clintonville

Dr. W. G. Arnold, who has practiced in Milwaukee for the past five years, has moved to Clintonville where he will practice as an associate of *Dr. Robert Bolinske.* Doctor Arnold is a graduate of Marquette University and served his internship at St. Joseph's and St. Anthony's Hospitals in Milwaukee. He has also had two years of surgical training in the New York City polyclinic hospitals.

Six Milwaukee Surgeons Win Honor

Six Milwaukee surgeons received fellowships in the American College of Surgeons at a meeting of the organization on September 26 at the Waldorf-Astoria in New York City. It climaxed the five day annual meeting. The Milwaukeeans who received the F.A.C.S. award are as follows: *Drs. G. E. Collentine, Jr., J. D. Levin, I. J. Ricciardi, H. F. Twelmeyer, Marvin Wagner, and S. K. Wynn.*

Doctor Shutkin Addresses National Group

Dr. Michael W. Shutkin, Milwaukee gastroenterologist and assistant clinical professor of medicine at Marquette University, appeared before the annual convention of the National Gastroenterological Association in New York City on October 22, where he presented a paper on "Significant Factors in the Etiology of Gastrojejunal Ulcer." Doctor Shutkin is president of the Wisconsin Chapter of the National Gastroenterological Association.

Physicians Return from South American Trip

Two Wisconsin physicians, *Dr. A. L. Banyai,* Wauwatosa, and *Dr. W. T. Clark,* Janesville, recently returned from an international conference on tuberculosis which was held in South America. The doctors visited hospitals and sanatoria in Buenos Aires, Argentina, Sao Paulo, Brazil, and Montevideo, Uruguay. Doctor Banyai is president of the American College of Chest Physicians.

Scientific Paper Presented by Milwaukeean

At a meeting of the Chicago Ophthalmological Society held on October 6, *Dr. L. L. Garner,* Milwaukee, read a paper entitled "Clinical Observations of the Effect of Cigarette Smoking on the Flicker Fusion Threshold of Normal Smokers and Non-Smokers." Co-authors of the paper were *Drs. E. F. Carl* and *E. E. Grossmann,* both of Milwaukee.

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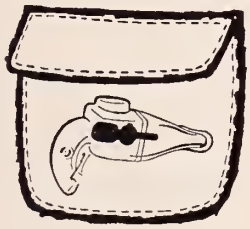

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1. Kaufman, R., and Farmer, L. (1951), Norisodrine by Aerohalor in Asthma, Ann. Allergy, 9:89, January-February.
2. Swartz, H. (1950), Norisodrine Sulphate (25 Per Cent) Dust Inhalation in Severe Asthma, Ann. Allergy, 8:488, July-August.
3. Krasno, L., Grossman, M., and Ivy, A. (1949), The Inhalation of 1-(3′,4′-Dihydroxyphenyl)-2-Isopropylaminoethanol (Norisodrine Sulfate Dust), J. Allergy, 20:111, March.

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Milwaukee Academy of Medicine

The 886th meeting of the Milwaukee Academy of Medicine was held at the University Club on October 21. As usual dinner preceded the scientific program which featured a talk by Dr. Paul D. White of Boston, Mass. Doctor White, who is executive director of the National Advisory Heart Council, chose "The Three Medical Eras" as the title of his presentation.

Milwaukee Neuro-Psychiatric Society

The members of the Milwaukee Neuro-Psychiatric Society held their most recent meeting at Columbia Hospital on October 15. The program was arranged by the staff of the departments of psychiatry, neurology, and neuro-surgery of the Hospital.

Milwaukee Oto-Ophthalmic Society

At the annual business meeting of the Milwaukee Oto-Ophthalmic Society the following officers were elected for 1952–1953:

President—*G. D. Straus, M. D.*
Vice-President—*H. C. High, Jr., M. D.*
Secretary—*E. E. Grossmann, M. D.*

SOCIETY RECORDS

New Members

Albert Liebman, 425 East Wisconsin Avenue, Milwaukee.

De Verne W. Vig, 110 West South Street, Viroqua.

Edward N. Vig, 110 West South Street, Viroqua.

S. H. Ferguson, 66 Pearl Street, New Lisbon.

C. L. Weston, New Lisbon.

J. E. Sweeney, St. Joseph Hospital, Marshfield.

G. B. Ellenz, Dells Clinic, Wisconsin Dells.

T. E. Henney, 207 West Cook Street, Portage.

M. L. Jaffee, Nekoosa.

H. R. Peters, 25 South Madison Avenue, Sturgeon Bay.

J. F. March, 415 Fourth Street, Algoma.

Changes in Address

B. W. Sitterson, La Crosse, to 3842 Beech Street, Mariemont, Ohio.

R. J. Mayer, Wood, to 710 Main Street, Racine.

R. M. Baldwin, Janesville, to 405 East Grand Avenue, Beloit.

E. V. Hastings, Milwaukee, to Medical College of Georgia, University Place, Augusta, Georgia.

J. C. H. Russell, Milwaukee, to 38 South Water Street, West, Fort Atkinson.

P. T. Bland, Jacksonville, Florida, to Westby.

R. T. Cunningham, Fort Harrison, Montana, to 1304 Chester Avenue, Bakersfield, California.

W. C. Curtis, Milwaukee, to 9128 West North Avenue, Wauwatosa.

R. H. Lehman, Milwaukee, to Veterans Administration Hospital, Wood.

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J. W. Frye,* Camp Carson, Colorado, to 1316 North Foote Avenue, Colorado Springs, Colorado.

F. A. Wierzbinski, Marshfield, to 521 South Governor Street, Iowa City, Iowa.

G. P. Fitzgerald, Indianapolis, Indiana, to 19 South Main Street, Janesville.

J. A. Means,* Milwaukee, to 605 South Rolla Street, Route 2, Box 17A, Rolla, Missouri.

H. Curtis Johnson, Madison, to 303 Willamette Street, Eugene, Oregon.

C. S. Peabody, Madison, to 582 Tod Lane, Youngstown, Ohio.

J. R. Evrard, Milwaukee, to 8345 Whitney Road, Fox Point.

E. T. Dunn, Milwaukee, to 1040 McCormick Street, Clifton Forge, Virginia.

E. C. Welsh, Wood, to Director, Department of Physical Medicine, Columbia Hospital, Milwaukee.

J. T. Hotter,* San Antonio, Texas, to 1563 South Seventy-Second Street, West Allis.

J. S. Stehlin, Cambridge, Massachusetts, to 1277 Commonwealth Avenue, Boston, Massachusetts.

T. J. Beno,* Wood, to Surgical Service, United States Army Hospital, Fort Riley, Kansas.

* Military Service.

DEATHS

Dr. Wilbur L. LeCron, retired Milwaukee surgeon, died on August 18 at a local hospital. He was 69 years old.

Born on January 5, 1883, the doctor received his medical education and degree at Johns Hopkins University School of Medicine, and took postgraduate work at the Universities of Freiburg and Liepzig in Germany. He served his internship at Hartford General Hospital, Hartford, Connecticut and came to Milwaukee in 1910 to be the first resident at Columbia Hospital. He remained on the staff of that hospital until his retirement in 1946, as well as serving as a pathologist on the staff of Milwaukee Children's Hospital.

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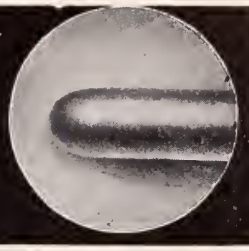

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"Migraine may appear during the first years of life. The presence of subjective signs, such as headache and flimmer scotoma, is often difficult to determine in young children. The true nature of the symptoms frequently remains obscure for years."

Vahlquist, B. and Hackzell, G.: Acta Paediatrica *38*: 622 (1949).

NO. OF CASES	SEX	AGE AT ONSET	CYCLIC VOMITING	DURATION OF ATTACK	INTENSITY
31	8 ♀ 23 ♂	3 yrs. (mean)	3 out of 31	2½ hrs.	severe in all cases

TABLE CONT'D

NO. OF CASES	UNILATERAL HEADACHE	NAUSEA	FLIMMER SCOTOMA	VERTIGO	HEREDITY
31	18 out of 31	31 out of 31	12 out of 31	6 out of 31	20 out of 31

(reference given above)

In a study of 400 adult migraine patients, it was revealed that 34% had suffered attacks before the age of 15.* These investigators concluded that childhood migraine was a much greater clinical problem than was previously believed and that psychodynamic mechanisms played an important part in the disease.

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In the adolescent age group, 12 to 18 years of age, the dosage may gradually be increased as necessary up to the usual adult dose, i.e., two tablets when the attack appears imminent followed by one tablet doses at half hour intervals until the attack is aborted. *(Total maximum dose for adults: six tablets for each attack.)*

* Katz, J., Friedman, A.P., and Gisolfi, A.: New York State J. Med. *50*: 2269 (Oct.) 1950.

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Doctor LeCron was a past president of the Milwaukee Surgical Society. He also held membership in the Milwaukee Academy of Medicine, the Medical Society of Milwaukee County, the State Medical Society, and the American Medical Association.

Survivors include his wife and a daughter.

Dr. William A. Meilicke, 74, former Balsam Lake physician, died on September 4 in a West Bend hospital. He was born on November 29, 1877.

The doctor attended the American Medical Missionary College and was graduated from the University of Colorado School of Medicine in 1903. He practiced first in Nicolett, Minn., and then in Minneapolis. About 1925 he moved his office to Balsam Lake where he practiced until 10 years ago when failing health forced his retirement.

Following his retirement he spent a number of years in Europe with his daughter and son-in-law and has more recently made his home with his son in Milwaukee.

Surviving are a son and a daughter.

Dr. Paul E. Pifer, Kenosha physician, died on September 7 in Rochester, Minn., following a long illness. He was 56 years old.

Born in Reynoldsville, Pa., on November 4, 1895, the doctor was a graduate of Western Reserve University School of Medicine and interned at Cleveland (Ohio) City Hospital. He served a surgical residency at Lutheran Hospital, Cleveland. In 1934 he opened his first practice in Kenosha.

Doctor Pifer did postgraduate work at Muirdale Sanatorium, Wauwatosa, and in addition to his private practice served as medical director of Willowbrook Sanatorium from 1944 until he retired because of ill health in November 1951. He had also served on the staff of St. Catherine's and the Kenosha Hospitals.

He was a director of the Kenosha County Anti-Tuberculosis and Health Association and a Fellow of the American College of Surgeons. Other affiliations included membership in the American College of Chest Physicians and Surgeons, the Kenosha County Medical Society, the State Medical Society, and the American Medical Association.

He is survived by his wife, a son, and a daughter.

Dr. Donald G. Hugo, 62, Oshkosh physician, died on September 14 at a local hospital, following an illness of several weeks.

Born in Chilton, February 12, 1890, he was graduated from Marquette University School of Medicine in 1911 and went to the Luther Hospital in St. Paul, Minn., for his two years of internship. The doctor opened an office in Oshkosh in 1913 to practice general medicine. He joined the U. S. Army Medical Corps in 1917 and was discharged in 1919. He then entered the Chicago Eye, Ear, Nose, and Throat College for specialized training and also went to school in New York City before returning to Oshkosh to practice with the late Dr. H. W. Morganroth. In 1928 he took further training at the Allgemeine Krankenhaus in Vienna, Austria.

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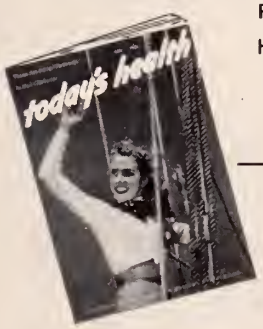

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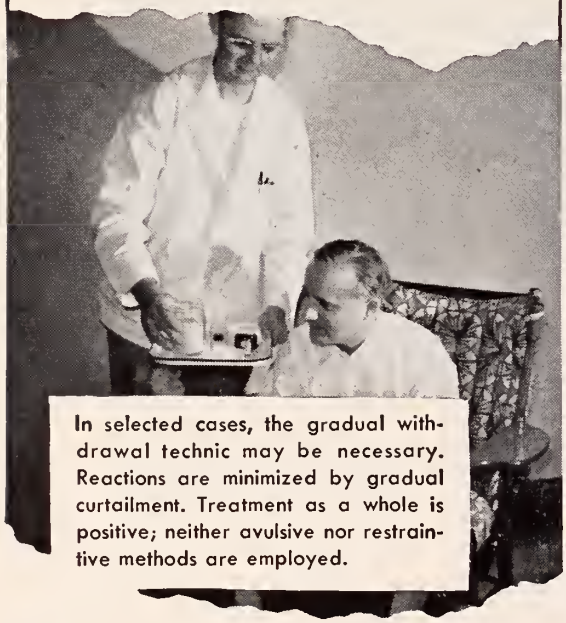

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Doctor Hugo was a past president of the Northeastern Wisconsin Oto-Laryngological Society, and a member of the Winnebago County Medical Society, the State Medical Society, and the American Medical Association.

Survivors include his wife, a son, and two daughters.

Dr. Albin A. Krygier, who had practiced medicine in Milwaukee for 44 years, died on September 15 at a local hospital. He was 71 years old.

A native of Indiana, the doctor was born in South Bend on January 30, 1881. He moved to Wisconsin as a youth and attended Marquette University School of Medicine for his M.D. degree. He served on the faculty of his medical school during the 1920's and was until recently on the staffs of St. Luke's, St. Joseph's and St. Michael's Hospitals.

He was a member of the Medical Society of Milwaukee County, the State Medical Society, and the American Medical Association.

Doctor Krygier is survived by his wife, two sons, Drs. A. J. and W. L. Krygier, and three daughters.

Dr. C. H. E. Wheeler, 69, Platteville physician for 42 years, died on September 17 in a local hospital. He was born November 1, 1882, in Beaver Dam.

A Carroll College graduate, Doctor Wheeler received his medical degree at Marquette University School of Medicine in 1909. He served his internship at Trinity Hospital, Milwaukee, and established his practice in Platteville in 1910.

He was a member of the Grant County Medical Society, the State Medical Society, and the American Medical Association.

Surviving are two sons, a sister, and two grandchildren.

Dr. Emmett F. Cook, Milwaukee physician, died on September 19 at a local hospital. He was 53 years old.

Born on February 28, 1899 at Poplar Grove, Illinois, the doctor received his medical degree from Marquette University School of Medicine in 1925. He established his practice in Milwaukee, and in addition to his private work taught at Marquette from 1925 until 1942 and at St. Joseph's Hospital Nursing School from 1926 to 1938.

For many years he was active in civic affairs. He was a past president of the Milwaukee Civic Alliance and had been a member of the school board since 1945, serving as president of the board for the 1951–52 term.

Doctor Cook was a member of the Medical Society of Milwaukee County, the State Medical Society, and the American Medical Association.

Survivors include his wife and a daughter.

Dr. Clarence A. Vogel, 72, died at his home in Elroy on September 29, following a long illness. He was born in Wilton on March 7, 1880.

The doctor received his medical education at Loyola University School of Medicine, graduating in 1904. He served his internship at Cook County Hospital, Chicago, and did postgraduate work at Colum-

bia University. After practicing for a time in Rushford, Minn., Doctor Vogel joined his brother, Dr. Carl C. Vogel, in Elroy in 1908. The partnership lasted until his brother's death in 1948.

Active in the civic affairs of his city, the doctor was mayor from 1934 to 1938, as well as having served as city health officer and as a member of the board of education. He had also been director of the Bank of Elroy.

Doctor Vogel was a member of the American College of Physicians and Surgeons, the Juneau County Medical Society, the State Medical Society, and the American Medical Association.

Survivors include his wife, a son, and a daughter.

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PHYSICIANS' EXCHANGE

Advertisements for this column must be received by the 25th of the month preceding month of issue. A charge is made of $2.00 for the first appearance of copy occupying 1 inch or less of space and $1.00 for each succeeding insertion of the same copy. Kindly accompany copy with remittance to cover number of insertions desired. Advertisements from members of the State Medical Society will be accepted without charge. Such copy will be taken out after its second publication unless otherwise requested. Where numbers follow advertisements replies should be addressed in care of The Wisconsin Medical Journal.

FOR SALE: One hundred milliampere x-ray, generator with tube stand, and tube for radiographic work. Very low price. Write to Mrs. M. P. Andrews, 835 N. 15th St., Manitowoc, Wis.

FOR SALE: Country practice with no competition. Only buy modern residence, with office and waiting room in residence—separate office entrance. Office in residence saves you office rent, phone, and secretary expense. Beautiful surroundings. Address replies to No. 440 in care of the Journal.

WANTED: General practitioner for general practice in central Minnesota, population 30,000. New office building, good equipment. Permanent association desired. Address box 443 in care of the Journal.

WANTED: A general practitioner to join Capital Clinic and Capitol Hospital group. Full or part time practice. Write 1971 West Capital Drive, Milwaukee, Wis. Phone, Uptown 1-9100.

WANTED: Ob-Gyn man who is certified or board qualified. Excellent opportunity with excellent hospital facilities. Financial arrangements open. Address box 444 in care of the Journal.

WANTED: Midwest group of 20 physicians have opening for an assistant in general surgery including traumatic, industrial, and minor injuries; liberal salary depending upon experience or previous training. Address replies to box 454 in care of the Journal.

PHYSICIAN WANTED, preferably out of internship, for general practice. Attractive salary and chance for partnership affiliation. New office building, good equipment, time off—good hunting and fishing. Address replies to box 421 in care of the Journal.

FOR SALE: Instruments and equipment of retiring eye, ear, nose, and throat physician who has been established in Wisconsin since 1916. Excellent opportunity for young man in city of 50,000. Address replies to box 449 in care of the Journal.

WANTED TO BUY: 100 MA x-ray and fluoroscopic unit such as the Picker Century; 2 hospital beds; electrocardiograph; infra-red light or baker; 2 treatment tables; set of book shelves; surgical instruments; and files. Address replies to box 450 in care of the Journal.

PHYSICIAN WANTED as an associate for a well established practice operating in connection with a 25 bed modern hospital in southwestern Wisconsin, not far from a larger city. Experience in surgery required. Liberal salary. No investment necessary. This opportunity is very attractive and unusual. A new modern house is available. Address replies to box 455 in care of the Journal.

FOR SALE: Light oak roll top desk with right side drawers, a swivel arm chair and matching straight back chair. Address replies to box 451 in care of the Journal.

WANTED: Physician as an associate to general practitioner in North Shore area of Milwaukee. Eventual full partnership possibilities. Modern, well equipped, air conditioned offices. Must be well trained. Excellent opportunity. Address replies to box 430 in care of the Journal.

FOR SALE: Three hospital beds with mattresses in very good condition, $55 each. Also a very large assortment of surgical instruments that we will have to get together on in order to set a price. For further information write or call E. A. Jenkins, River Falls Clinic, River Falls, Wis.

PHYSICIAN WANTED, preferably out of internship, as associate in general practice which includes a liberal amount of surgery. Chance for partnership affiliation. Address replies to box 456 in care of the Journal.

GENERAL PRACTITIONER WANTED: A lucrative practice in a large rural area in northern Wisconsin available for a military exempt M. D. No competition, present physician specializing. Complete set of equipment available at token of real value if desired. Address replies to box 457 in care of the Journal.

PEDIATRICIAN would like to locate in Wisconsin with a group or as an associate. Interested in a city with a population between 8,000 and 40,000. Address replies to box 458 in care of the Journal.

THORACIC AND GENERAL SURGEON, qualified and certified, age 39, desires location, association or clinic. Straight thoracic surgery preferred. Presently Chief, Surgical Services and Thoracic Surgeon, Veterans Administration Hospital. Address replies to box 459 in care of the Journal.

AVAILABLE FOR YOUNG PHYSICIAN: Office space and equipment for general practitioner. Excellent location in business-residential section of Madison. Will arrange lease and ultimate purchase of equipment, if so desired. Write box 460 in care of the Journal to arrange for interview and inspection of office.

WANTED: Doctor who would like to settle in small active community near Milwaukee. One year free rental of office and living quarters, same to be patterned according to doctor's needs. Contact A. N. Meyer, Fredonia Civic Club, Fredonia, Wis.

FOR SALE: All steel mahogany color examining table, instrument cabinet, stool, and waste receptacle. All pieces new except for slight damage to upholstery of examining table which can be repaired. Also brand new Castle sterilizer. Will sell all cheap to move fast. Address replies to box 461 in care of the Journal.

FOR SALE: Complete eye, ear, nose, and throat equipment, including all surgical, diagnostic, and refracting instruments. Make an offer for quick sale. Address replies to Mrs. D. G. Hugo, 508 Washington Blvd., Oshkosh, Wis.

PHYSICIAN WANTED to associate with three man, well established clinic, in a city of 4,000. Class A hospital connections. General practice and surgery. Address replies to box 462 in care of the Journal.

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ICAN MEDICAL ASSOCIATION news notes NOVEMBER, 1952

AMA news written especially for use in state medical journals

Annual Congress on Industrial Health

Improving health services of our nation's working force will be the over-all theme of the Annual Congress on Industrial Health, sponsored by the AMA's Council on Industrial Health. Workers, industrial leaders and medical men will assemble for this 13th annual conference January 21–22 at the Drake Hotel, Chicago.

Highlights of the Congress include sessions on small plant industrial health services, human relations, and aspects of occupational cancer. One important session will endeavor to answer the question —how can management, labor and medicine best help maintain the health of our national work force?

On Tuesday, January 20—the day before the Congress convenes—a joint conference will be held for members of the Council and chairmen of state society committees on industrial health. Tuesday afternoon's program will be devoted to round table discussions stressing three main areas of industrial health—education, service and research. Gradie R. Rowntree, M.D., chairman of the committee on industrial health of the Kentucky State Medical Association, will preside.

Students Read "Today's Health"

"Today's Health" magazine is taking its place with regular textbooks on the college campus. More than 1300 freshman physical education students at the University of Illinois at Champaign–Urbana are reading the magazine as part of their regular classroom assignment. A special supplementary study sheet called "Classroom Discussion Topics" is being supplied free of charge by the AMA's Bureau of Health Education as an aid to classroom discussion.

State AMEF Chairmen to Meet

American Medical Education Foundation state chairmen will kick off the 1953 fund-raising drive with a meeting Sunday, January 25, at the Sheraton Hotel in Chicago. This second annual meeting will launch officially the medical profession's concerted effort during the coming year to raise voluntary funds to assist the country's medical schools. Keynote speaker will be L. D. McGuire, M.D., AMEF chairman for Nebraska.

Chief value of the meeting will be to exchange experiences and ideas on local fund-raising promotions. Representatives from every state will be on hand for the one-day session.

British Films Added to AMA Library

Two British films—"Some Aspects of Cancer-Skin" and "Some Aspects of Cancer-Rectum"—will be available about October 1 from the AMA's Committee on Medical Motion Pictures. The films are suitable for professional meetings only.

AMA's Story Off the Presses

A new pamphlet—"The AMAzing Story"—prepared by the American Medical Association, gives the general public a brief summary of the ways in which the AMA serves an average American family. This booklet pictorializes the many ways the Association serves Mr. and Mrs. Joe Typical and family. The pamphlet will be distributed to all AMA members December 1.

Exhibit Catalog Now Available

If your medical society is anticipating displaying health exhibits at local fairs and meetings during the coming year, you'll be interested in the attractive new exhibit catalog prepared by the AMA's Bureau of Exhibits. This booklet carries pictures of 25 different health exhibits, with brief descriptions and such installation data as the minimum space and electrical requirements and shipping weights. All of these exhibits are available on a loan basis from the Bureau. The booklets are being mailed to secretaries of state medical associations for distribution to county societies.

'52 "Apparatus Accepted" Available

The 1952 edition of "Apparatus Accepted," a publication of the AMA's Council on Physical Medicine and Rehabilitation, will be available December 15. The 60-page booklet includes a complete listing of diagnostic and therapeutic devices which have been accepted by the Council. Among other things, the booklet lists such items as audiometers and hearing aids, electrocardiographs, oxygen therapy apparatus, incubators, inhalers and resuscitators, and metabolism testing equipment. Copies may be secured on request through the Council.

New Medical Care Exhibit

The story of how local medical societies bring medical care and medical services to more and more American people is the subject of a new exhibit which is nearing completion by the AMA's Bureau of Exhibits. "You and Your Medical Care" exhibit features emergency call services, voluntary health insurance, early detection and prevention of such diseases as cancer and TB, community health councils, grievance committees and source of health education information.

A separate unit has been designed for each subject, making the exhibit suitable for showings in every community . . . any portion of the exhibit may be omitted if a state or county society has not yet developed a program on a certain subject. The exhibit will be available shortly after the first of the year.

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COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Ashland-Bayfield-Iron	C. A. Grand 522 W. 2nd Ashland	J. E. Kreher 522 W. 2nd St. Ashland	
Barron-Washburn-Sawyer-Burnett	R. E. Lund Cumberland	Clive J. Strang Barron	Second Tuesday 7:30 p.m.
Brown-Kewaunee-Door	J. L. Ford 3030 S. Webster Green Bay	G. M. Shinners 409 E. Walnut Green Bay	Second Thursday*
Calumet	E. P. Larme New Holstein	J. M. Guthrie Brillion	
Chippewa	T. D. Foster Cornell	B. F. Rahn Cadott	Second Tuesday
Clark	K. F. Manz Neillsville	J. W. Koch Owen	
Columbia-Marquette-Adams	R. F. Inman Montello	E. G. Nafziger Oxford	Second Tuesday 7:00 p.m.
Crawford	O. E. Satter Prairie du Chien	H. L. Shapiro Prairie du Chien	
Dane	J. K. Curtis 2500 Overlook Ter. Madison	G. E. Oosterhous 304 W. Washington Madison	Second Tuesday
Dodge	H. G. Bagley Beaver Dam	R. E. Urbanek Beaver Dam	Last Thursday*
Douglas	F. G. Johnson 1507 Tower Superior	F. W. Reibold 1574 Ogden Superior	First Wednesday** Badger Room of the Hotel Superior
Eau Claire-Dunn-Pepin	W. G. Cameron 131 S. Barstow Eau Claire	H. E. Sorensen 314 E. Grand Eau Claire	Last Monday
Fond du Lac	F. J. Cerny 80 Sheboygan Fond du Lac	N. O. Becker 104 S. Main Fond du Lac	Fourth Thursday*
Forest	O. S. Tenley Wabeno	D. V. Moffet Crandon	
Grant	N. G. Rasmussen Montfort	H. W. Carey Lancaster	Last Thursday, March, June, Sept. and Nov.
Green	D. D. Ruehlman Monroe	L. G. Kindschi Monroe Clinic Monroe	
Green Lake-Waushara	Roy Hong Wild Rose	R. S. Pelton Markesan	Last Thursday, every other month starting in Jan.

List of Officers and Scheduled Meetings of County Medical Societies—Continued

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Iowa	C. L. White Mineral Point	H. M. Walker Dodgeville	First Thursday following first Monday
Jefferson	E. A. Miller 133 Riverlawn Watertown	E. J. Netzow Lake Mills	Third Thursday*
Juneau	J. S. Hess Mauston	M. S. Tverberg Mauston	Second Tuesday Hess Clinic in Mauston
Kenosha	H. L. Schwartz 625 57th Kenosha	Helen A. Binnie 7609 25th Kenosha	First Thursday* Elks Club Kenosha
La Crosse	J. J. Satory 1707 Main La Crosse	D. M. Buchman 308 Newburg Bldg. La Crosse	Third Monday
Lafayette	D. J. Garland Shullsburg	N. A. McGreane Darlington	First Tuesday
Langlade	D. W. Dailey Elcho	F. H. Garbisch Antigo	Second Wednesday
Lincoln	L. J. Bayer Merrill	J. D. Millenbah Merrill	
Manitowoc	C. J. Radl Wood Block Manitowoc	W. C. Randolph 819 Hancock Manitowoc	Last Thursday
Marathon	D. M. Green Trust Bldg. Wausau	G. R. Hammes 529½ 3rd Wausau	
Marinette–Florence	J. M. Bell 1723½ Main Marinette	R. J. Rogers Oconto	Third Wednesday St. Joseph's Hospital
Milwaukee	N. J. Wegmann 2510 W. Capitol Milwaukee	W. T. Casper 2218 N. 3rd Mr. J. O. Kelley, Ex. Sec. 208 E. Wisconsin	Second Thursday
Monroe	C. E. Kozarek Tomah	J. S. Mubarak Tomah	Third Monday
Oconto	H. A. Aageson 1113 Main Oconto	G. R. Sandgren Suring	
Oneida–Vilas	G. R. Thuerer 1020 Kabel Rhinelander	Marvin Wright 1020 Kabel Rhinelander	Monthly
Outagamie	W. S. Giffin 601 W. College Appleton	F. J. Rankin 214 E. Wisconsin Appleton	Third Thursday* Elks Club 6:30 p.m.
Pierce–St. Croix	E. F. Hill Spring Valley	P. H. Gutzler River Falls	Third Tuesday
Polk	W. A. Fischer Frederic	G. B. Noyes Centuria	Third Thursday 7 p.m.
Portage	M. G. Rice Stevens Point	H. A. Anderson Stevens Point	
Price–Taylor	J. L. Murphy Park Falls	J. J. Leahy Park Falls	Last Saturday, Feb., May, Aug., and Nov.
Racine	J. M. Albino 710 Main Racine	J. G. Jamieson 812 Main Racine	Third Thursday
Richland	J. I. Spear Richland Center	L. M. Pippin Richland Center	First Tuesday Richland Hospital
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Shawano	J. H. Terlinden Bonduel	R. C. Cantwell Shawano	Third Tuesday
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Trempealeau–Jackson–Buffalo	F. T. Weber Arcadia	E. P. Rohde Galesville	Second Tuesday
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Walworth	R. S. Galgano Delavan	K. C. Bill Elkhorn	Second Thursday*
Washington–Ozaukee	P. B. Blanchard Cedarburg	K. F. Pelant Grafton	Fourth Thursday
Waukesha	J. C. Frick 262 W. Broadway Waukesha	J. A. Bartos 707 Oakland Waukesha	
Waupaca	L. G. Patterson 122 S. Main Waupaca	R. E. Bollnske Clintonville	
Winnebago	W. E. Clark 19 Jefferson Oshkosh	B. S. Greenwood 19 Jefferson Oshkosh	First Thursday
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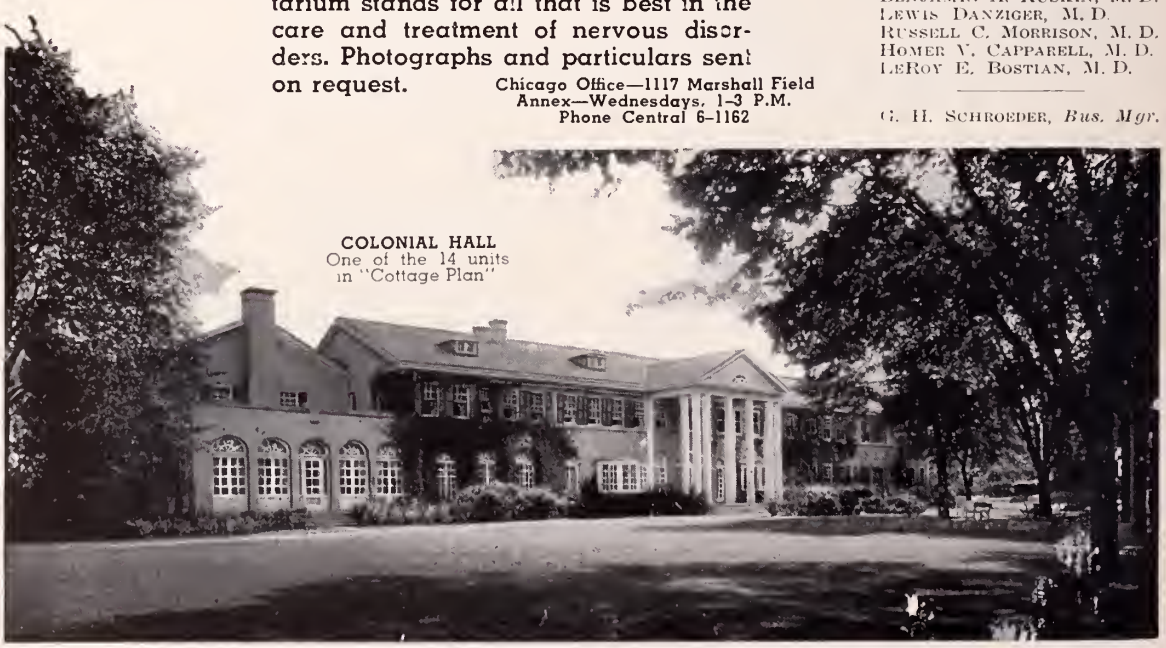

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1. Michael, N.: Ohio State M. J. *48*:42, 1952.
2. Carter, S., in Conn, H. F.: Current Therapy 1952, Philadelphia, W. B. Saunders Company, p. 610.
3. Lennox, W. G., in Cecil, R. L., and Loeb, R. F.: A Textbook of Medicine, ed. 8, Philadelphia, W. B. Saunders Company, 1951, p. 1379.
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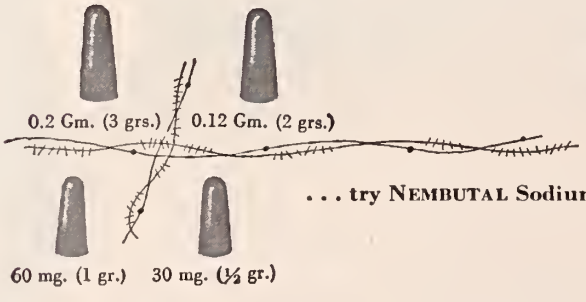

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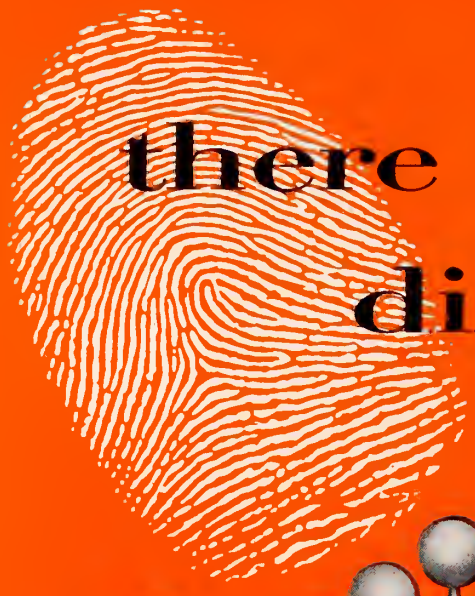

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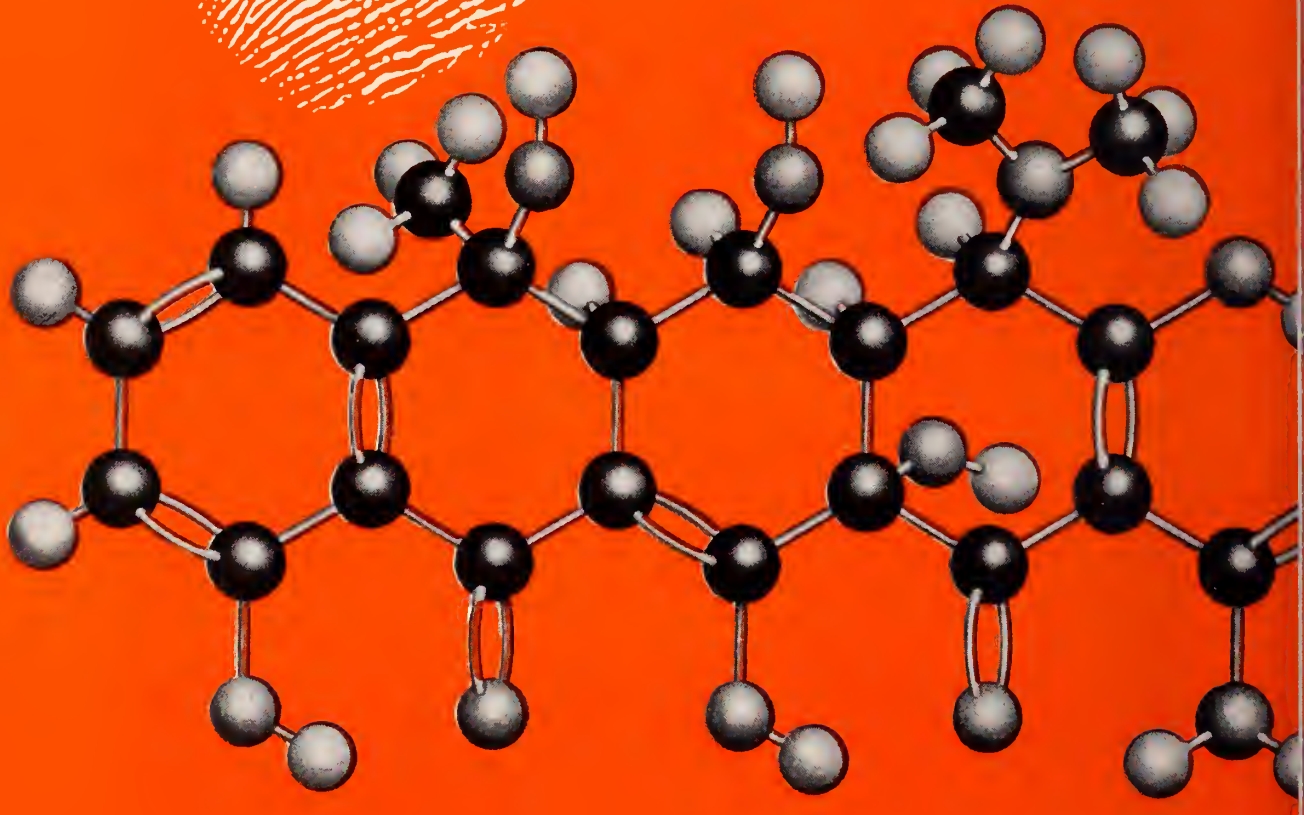

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FLUORINE	3.0 mg.	*NIACIN	6.7 mg.
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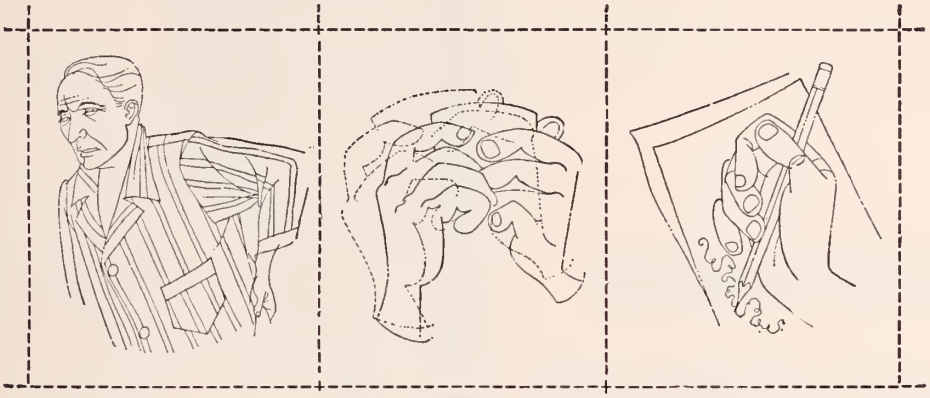

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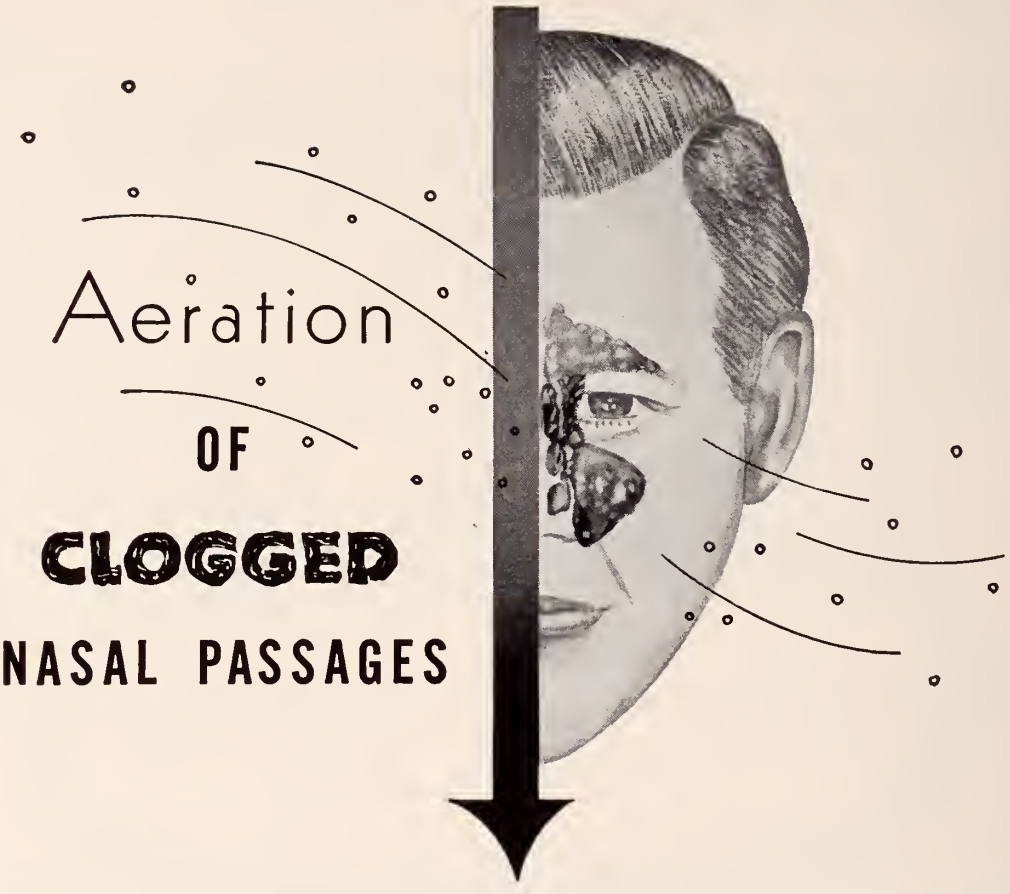

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1. Van Alyea, O. E., and Dannelly, Allen: *Arch. Otolaryng.*, 49:234, Feb., 1949.

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« « « EDITORIALS » » »

Education . . . Not Inquisition

Elsewhere in this issue of the *Journal* is a description of a research project which is to be launched in January, and which will require 100 per cent cooperation of Wisconsin physicians and hospitals to succeed. It is to be an intensive study of maternal deaths, and its anticipated goal is to reduce even further the loss of life associated with delivery.

In order to make this study of value and to enlist the wholehearted cooperation of the profession elaborate methods are being employed so that the committee which will review the circumstances have no way of knowing what physician and hospital were involved in the case. It is significant that those physicians who will gather the data are designated as "interviewers" and not "investigators."

While Wisconsin's record in respect to maternal mortality has improved steadily, it is felt by the Committee on Maternal and Child Welfare that even greater improvement can be made through individualized studies of the 40 to 50 maternal deaths which occur in Wisconsin annually.

During the ensuing year some 40 to 50 physicians who have lost a maternal patient will be asked to assist the Committee on Maternal and Child Welfare to review the various circumstances of the case. If you should be one of those contacted, your wholehearted cooperation is enlisted. The study is one of education, not inquisition.

Don't Waste Blood

A timely article on the conservation of blood, written by Dr. T. J. Greenwalt, appears in this issue of the Wisconsin Medical Journal. It is well worth a minute perusal by every member of this Society.

The various blood banks throughout the state have done such an excellent job in supplying us with the amounts of blood needed that there is a tendency on the part of many of us to order a great deal more for a particular patient than is actually necessary, and to neglect to check on the technic of administration to prevent any wastage at that point.

Doctor Greenwalt and the committee on blood conservation are to be congratulated on bringing these points before us. I am sure that if the last line of the paper, "Volunteer donors are all wonderful people and are justly proud of that pint which they gave. Handle with Care!", could be pasted on each pint of blood, it would serve as an ever present reminder to us, and this greatest of our natural resources would be conserved.

Comments from the Wisconsin Press

Domestic Law by Treaty?

The Des Moines Register accuses the American Medical Association of being "jittery" because the AMA has warned that socialized medicine might easily be inflicted upon the American people by means of an international treaty.

We don't think the AMA is jittery at all. As a matter of fact, the medical profession is doing the American people a service by pointing to certain dangers that exist. The dangers become not one whit less real by ridiculing those who point to them.

In a recently issued pamphlet, the medical association pointed to the activities of the International Labor Organization, which is one of the subsidiaries of the United Nations. The ILO has a staff of researchers and secretaries . . . . who last June drew up a proposed agreement on "minimum standards of social security." This agreement contained a number of clauses on medical benefits.

The Des Moines Register has this to say about the ILO and its delegates:

"In practice, they draw up some pretty fancy agreements which very few of the member countries ever ratify, and a good many of those who do ratify do not bother to put them into effect. . . . Now the AMA is excited for fear socialized medicine will slip into the U. S. by the back door, through the treaty power. . . . Actually the danger (if it is a danger) is negligible. The back door is ever so much harder to penetrate than the front door. A treaty takes a two-thirds vote of the senate, which is very hard to get on anything so controversial. . ."

The Des Moines Register treats these "pretty fancy" international agreements far too lightly. It apparently assumes that we should continue a practice of ratifying treaties without later bothering to put them into effect.

It assumes that unless such a treaty is implemented by affirmative action of the U. S. Senate and House of Representatives, it is not dangerous and is ineffective. Nothing could be farther from the truth. Once such an agreement is ratified by a two-thirds vote of the U. S. Senate, it becomes the law of the land and individuals, states and the U. S. government itself are bound by its provisions.

It is true that it is difficult to get a two-thirds affirmative vote in the Senate. But it is much easier to get it in the Senate than it is to pass such a piece of legislation through both houses of the American congress and have it subsequently approved by the president. In the latter process, at least, any issue is fully debated and the American people, by the time of final approval, are fully aware of what such a scheme contains.—WISCONSIN STATE JOURNAL, November 12, 1952.

* * *

When Two Lobbies Scheme

Americans who have been demanding a curb on extravagance in government might well give more attention to the behind the scenes "log rolling" of the large pressure groups.

An example has just been cited by Dr. R. J. Wilkinson, president of the Southern Medical Association. It should concern veterans, doctors and other citizens concerned over overexpansion and overspending in the federal government.

The veteran's administration already has more than enough hospital capacity . . . yet more hospitals are being built.

Doctors are overwhelmingly opposed to further extension of government in the field of medicine. Yet, Dr. Wilkinson says, leaders in the powerful American Medical Association have told him repeatedly that the AMA must maintain a "hands off attitude" toward the veterans administration hospital program.

The reason? Dr. Wilkinson says that high ranking officers of the AMA explain privately that it's because the American Legion wants more VA hospitals built, and the American Legion lobby has been helping the AMA stave off federal compulsory health insurance legislation.—MILWAUKEE JOURNAL, November 11, 1952.

* * *

New Hospitals Change Rural Scene

The opening of a new 32 bed, $450,000 hospital in the rural community of Boscobel a few days ago got only slight attention outside that immediate area. It was an example, though, of something very important that has been happening to improve rural health services in Wisconsin.

Since the federal hospital aid program went into effect in 1948, there have been 12 new hospitals completed with such aid in Wisconsin communities where the area served is more than half rural. . . .

Some of these new rural hospitals are very small. The smallest is the eight bed hospital at Stanley and the largest at Monroe (66 beds.) . . . The total of 1,073 beds in new rural Wisconsin hospitals built or started since 1948 isn't all increase. Some will replace very old, inadequate, smaller hospitals. The new ones are as fine, complete and modern for the size as will be found anywhere . . . which are factors that will attract and hold good doctors and staff.—MILWAUKEE JOURNAL, October 22, 1952.

Maternal Mortality Survey and Study Plan

By T. A. LEONARD, M. D.
Madison

THE Wisconsin Society of Obstetrics and Gynecology decided unanimously at its October meeting in 1951 to sponsor the formation of a "Maternal Mortality Survey and Study Plan" for the State of Wisconsin, which had been recommended in 1950 to the House of Delegates of the State Medical Society by the Committee on Maternal and Child Welfare. This sponsorship developed from the knowledge obtained by facts brought to light by such surveys conducted in other states and large cities of the country. Such studies have indicated that up to 50 per cent of the maternal deaths might have been prevented. It was also shown that factors concerned with maternal demise were not always matters of neglect, but often times were due to failure of the application of certain obstetric principles which were not a part of common knowledge. In certain instances the factors were concerned with hospital care and occasionally the fault of the patient herself.

Considering that the three previous major causes of maternal deaths—infection, toxemia, and hemorrhage—have shown marked decrease in the past 10 years, it becomes apparent, that, if further improvement in the obstetric situation were to be accomplished, it was necessary to look toward the medical complications as a cause of maternal death and to learn more about the other causative factors which now exist.

It is the purpose, then, of this project to learn first of all what the present causes of maternal death are. This can only be accomplished by obtaining all the details which are in any way connected with each and every maternal death, and then to have these data impartially studied and reviewed. When there has accumulated a sufficient number of analyses as to causative factors, a starting point will have been reached for looking toward means of further improvement in the maternal mortality rates in Wisconsin.

The House of Delegates of the State Medical Society in 1951 approved a resolution for the establishment of a maternal mortality survey plan for Wisconsin. The committee was then formed and during the past year has had many meetings in conjunction with the Committee on Maternal and Child Welfare of the State Medical Society. Plans for the establishment of such a survey in the state were made as follows:

Every state in the Union where maternal mortality studies had been made were written to suggesting that they send to us any and all information which they had available concerning their studies. Most states were generous and complied in detail. This material was added to by personal visits to the representatives of the states where the most successful surveys had been conducted. With this material at hand—the Wisconsin committee met on several occasions and carefully reviewed each plan —the committee eventually established a plan which it is felt is better than any now extant.

It was agreed by the joint committees that if the plan was to be of value, certain conditions must be met:

(1) It must be thorough.

(2) The information obtained on each maternal death must be complete to the finest detail.

(3) Such information should be obtained by interviewing the hospital and the physician under whose care a death occurred.

(4) The interviewers should be physicians competent to obtain the information.

(5) The interviewing physician should be tactful and impersonal and should not be a resident of the local or nearby community in which the death occurred.

(6) A separate study committee should be created and that the members of said committee should not take part as interviewers.

(7) That all information obtained be presented to the study committee in a purely anonymous form, with obsolutely no information concerning the identity of the patient, the hospital, or the physician.

(8) That the study committee include at least one general practitioner among its members.

(9) That the information obtained be reviewed in detail, with the application of sound obstetric principles and judgment and the consideration of special circumstances—an opinion arrived at as to the preventability or non-preventability of the death.

(10) That each physician under whose care a death occurred might feel free to request a report after the study committee had completed its review and made conclusions.

(11) Lastly, all information would be under the control of the State Medical Society and would be used purely for study and information relative to the obstetric situation in the state. As the information accumulated, it could be summarized and used for educational purposes.

The Council of the State Medical Society approved the committee's efforts; therefore, the recommendations were presented to the House of Delegates for approval and the plan was favored unanimously. The president-elect of the State Medical Society in his acceptance speech stated that this plan was the most important piece of legislation to come before the House during its session and urged cooperation of all physicians in the state to aid in the successful working of the plan.

Twenty physicians have been chosen to do the interviewing, which means that they will each inter-

view two or three cases a year. The physicians appointed are as follows:

C. D. Neidhold, M. D., Appleton
W. O. Paulson, M. D., Eau Claire
J. J. Boersma, M. D., Green Bay
J. F. Egan, M. D., La Crosse
Woodruff Smith, M. D., Ladysmith
T. J. Rice, M. D., Marshfield
R. E. Campbell, M. D., Madison
H. M. Carter, M. D., Madison
W. V. Luetke, M. D., Madison
G. C. Hank, M. D., Madison
R. E. McDonald, M. D., Milwaukee
M. A. Krembs, M. D., Milwaukee
R. S. Cron, M. D., Milwaukee
L. T. Servis, M. D., Milwaukee
G. S. Kilkenny, M. D., Milwaukee
F. N. Pansch, M. D., Neenah
Marvin Wright, M. D., Rhinelander
Florence A. Duckering, M. D., Sheboygan
J. W. McGill, M. D., Superior
J. M. Freeman, M. D., Wausau

The Study Committee will meet periodically to review the cases. This is intended as purely an information gathering project—no attempt at third degree or censorship will be made. The following is a list of the members of the Study Committee:

T. A. Leonard, M. D., Madison, Chairman
J. W. Harris, M. D., Madison
F. J. Hofmeister, M. D., Milwaukee
Alice D. Watts, M. D., Milwaukee
R. J. Sanderson, M. D., Beloit
E. D. Wilkinson, M. D., West Allis

If this project receives the full cooperation of all, and if, when it is working as it should and in the course of its workings, it can, by educational means, be the medium through which twenty lives or more—or ten lives—or five lives—or even the life of ONE mother can be saved, then the efforts directed toward this project will reflect a further advance in obstetric practice.

BUREAU FOR HANDICAPPED CHILDREN SCHEDULES ORTHOPEDIC FIELD CLINICS

Orthopedic field clinics for the first half of 1953 have been scheduled by the Bureau for Handicapped Children, State Department of Public Instruction. The clinics are conducted for persons under 21 years of age who come within the state's definition of a crippled child. It is preferred that referrals be made by the family physician, but when this is not feasible, arrangements may be made by writing to the Bureau. Unless otherwise directed, forms for the purpose of referral may be obtained from the Bureau for Handicapped Children, and should be requested in advance of the clinic date. It is important that the Bureau know well in advance the number of persons to be examined so that plans may be made for the required personnel.

Families who return the signed referral form will be notified of the hour of their appointment a few days before the clinic. Parents and physicians are invited to attend the clinic with the child; and, if the public health nurse believes that the child referred to the clinic for orthopedic reasons is also in need of other services, the Bureau asks that it be notified of this fact.

Lancaster	December 30
Ashland	February 11, 12
Manitowoc	February 19, 20
Marinette	February 25
Kenosha	March 4, 5
Racine	March 12, 13
Green Bay	March 19, 20
Eau Claire	March 26, 27
Wausau	April 1, 2
Sheboygan	April 16, 17
La Crosse	April 21, 22, 23, 24
Superior	April 29, 30
Appleton	May 7, 8
Chippewa Falls	May 21, 22
Fond du Lac	May 28, 29
Rhinelander	June 3

Inquiries concerning these clinics may be addressed to the Bureau for Handicapped Children, Room 146 North, State Capitol, Madison 2, Wisconsin.

Vascular Crisis in Atrophic Cirrhosis of the Liver*

By JACOB K. BERMAN, M. D., EDWARD J. BERMAN, M. D.
and ELMER D. HABEGGER, M. D.
Indianapolis, Indiana

FOR the past six years, one of us (J. K. B.) has been investigating various aspects of atrophic cirrhosis of the liver in the experimental animal and and in man. Interest in the disease is increasing because cirrhosis is more prevalent now and may be encountered in all ages, including infancy.

The etiology of atrophic or portal (Laennec's) cirrhosis is not definitely known although alcoholism is now regarded as only one of the many factors which ultimately produce changes leading to a fibrotic shrunken liver. For this reason, the term "alcoholic" cirrhosis should be used selectively.

Among the more common causes of atrophic cirrhosis, in addition to alcohol, are the following: malnutrition with avitaminosis; protozoan infections such as malaria and syphilis; virus infections which may cause infectious hepatitis, or homologous serum jaundice, drugs such as sulfonamides, aureomycin, and arsenic; and hypothetical hepatotoxins thought to be present in burns, and toxemia of pregnancy (including acute yellow atrophy.) In addition, the rather vague and loosely-defined syndrome which was formerly known as Banti's disease or Banti's syndrome and which consists of congestive splenomegaly with hypersplenism, portal hypertension, and portal cirrhosis is still a pathologic enigma. Lastly, we are convinced from our experimental work and the clinical observation of one case that extensive arteriovenous communications in the liver due to severe trauma may produce the same ultimate fibrosis which is seen in any wide-spread liver damage. The scope of this paper does not include a consideration of early symptoms and signs, laboratory tests, prognosis based on clinical findings, or methods of diagnosis and treatment. However, many of these problems have been discussed in previous publications.[1-4] A discussion of the vascular derangements in the cirrhotic liver may lead to a clearer concept of the behavior of the disease, and ultimately to better methods of prevention and control of this lethal malady.

Normal Circulation of the Liver

We have previously referred to the peculiar form of circulation of the liver in which the endothelium is closely applied to the secreting liver cells.[5] Although the walls of these intrahepatic vessels are as thin as those of the capillaries, their diameters are much greater and the rate of flow slower so that they have come to be known as lacunar vessels or sinusoids; the term "sinus" generally being applied to the large thin walled veins of the dura mater. There are no connective tissue cells between the single layered endothelium and the liver cells. Capillaries are embedded in connective tissue even though occasionally they approach close to the epithelium surrounding them. It is very significant that in portal cirrhosis the great amount of proliferation of fibrous tissue and, for that matter, of regeneration is not around the sinusoids which are distorted and obliterated but around the vessels which lie in the portal canals and are surrounded by fibrous tissue.

Moreover the sinusoids are not connections between an artery and a vein like the capillaries, rather they are subdivisions of veins. Thus, the portal vein enters the liver and is subdivided by cords of hepatic cells into sinusoids, which reunite to empty into the hepatic veins and then into the inferior vena cava. This same type of venous circulation occurs in the Wolffian bodies, and it is probable that this form of circulation represents a primitive type of vascularization, since a single vessel passing by or through an organ provides it with both afferent and efferent vessels. Such an arrangement permits long and intimate contact with hepatic tissue. Elsewhere in the body the arteriovenous circulation requires the presence of two channels with currents flowing in opposite directions.

The hepatic artery supplies blood to the connective tissue of the liver, the walls of blood vessels and bile ducts, and then through its small terminal capillaries joins the sinusoids. Approximately one-third of the blood flowing through the normal liver comes from the hepatic artery and two-thirds from the portal vein. The capsule, framework, and cells form a soft elastic organ composed of an intercrescence of vascular endothelium and hepatic parenchyma, with great variations in external and internal pressures.

Pressures in the Portal System

The pressure gradient in the portal system depends upon the entire splanchnic vascular bed and its organs which constitute a huge hegemonic reservoir influencing volume and rate of flow in and around the liver. Physiologic variations in the blood supply are not limited to the liver but extend to the great mesenteric basin and its organs, particularly the spleen because this organ contributes one-fourth of the blood volume flowing to the liver. It is able to store large quantities of blood in the event of congestion within the liver, and conversely it is

* Presented by Dr. J. K. Berman before the One Hundred and Eleventh Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 1952.

From the departments of surgery, Indianapolis General Hospital and the Indiana University Medical Center. Aided by a grant from the Charles J. Wolf Foundation for Medical Research.

able to release much of its storage should liver demands require greater amounts of blood at any one time. The alimentary canal contributes 75 per cent of the portal blood volume, and obviously its demands during digestion and rest alter the volume of blood reaching the liver.

Normally there is a gradual fall in hydrostatic pressure from the mesenteric veins to the vena cava. Pressure in the mesenteric veins is approximately 26 to 30 mm. of mercury; and, after they unite to form the portal vein, the pressure falls to about 6 to 8 mm. of mercury. In the sinusoids it is in the neighborhood of 3 to 4 mm. of mercury, and this is reduced to 1 to 2 mm. of mercury in the hepatic veins, falling to less than a half of a millimeter of mercury in the vena cava.[6-7] Starling explained the interchange of body fluids through passive capillary endothelium on the basis of osmotic and hydrostatic pressure differentials. The osmotic pressure on the venous side of the capillaries is about 26 mm. of mercury. Since the hydrostatic pressure within the sinusoids is only 3 to 4 mm., it must be assumed that the osmotic pressure is equally low.[6] This is probably true because the lymph coming from the liver is extremely high in protein, approximating that of blood plasma. In fact, our studies and those of others show that the proteins in hepatic lymph amount to approximately 4 to 6 Gm. per cent.[6,8] The intrahepatic vessels are under autonomic nervous and hormonal control, integrated with the splanchnic bed so that compensatory pressure regulations can take place without impedance of the venous flow. (Chart 1)

The hepatic artery usually has a pressure of 120 mm. of mercury. It joins with the portal venous radicles in the sinusoids and interestingly enough falls to a common pressure in these channels. In other words, the capacious portal vein with its low pressure is joined by the exiguous hepatic artery with its high pressure in the sinusoids where both reach a common level of approximately 3 to 4 mm. of mercury, probably because of the resistance to hepatic arterial branches in their course through the connective tissue before they reach the sinusoids. The common denominators of liver circulation are the sinusoids filled with two-thirds portal and one-third hepatic arterial blood and behaving more or less like semi-permeable membranes permitting the ingress of fluid, food, and oxygen, and the egress of lymph containing anywhere from 4 to 6 Gm. per cent of protein.

Thus, we may assume that blood flows through the liver guided by pressure gradients in an expansible reservoir which is more or less under vasomotor control. Rate of flow and volume may be affected by the demand for blood elsewhere or by an impedance of flow to the heart or by variations in blood volume.

Oxygen in the Portal System

The normal oxygen content of circulating arterial blood is anywhere from 16 to 20 volumes per cent,

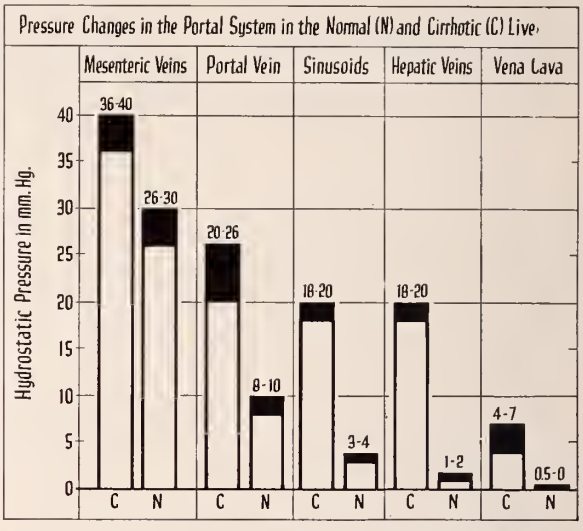

Chart 1—Hydrostatic pressures in the normal and cirrhotic portal system. There is a progressive fall in the normal which is maintained in the cirrhotic, but on a much higher level indicating hemodynamic interference. Pressures in the hepatic veins are lower until collaterals form, then they rise but are never as low as the highest normal pressures. Perhaps here is the criterion for the selection of cirrhotic patients who might benefit from hepatic, splenic, and left gastric arterial ligations.

the latter figure indicating complete saturation which is rarely achieved; the average being about 18 to 19 volumes per cent with little if any loss until the capillaries are reached. Venous oxygen in the peripheral blood is 12 to 14 volumes per cent, and the average arteriovenous difference varies between 4 and 7 volumes per cent. It was formerly thought that portal blood was about 50 per cent saturated with oxygen.[9] Our studies show that the arterio-portal-venous difference varies from 3½ to 6 volumes per cent, and the arterial-hepatic-venous difference is 2½ to 4½ volumes per cent. This does not differ greatly from the results obtained by other investigators.[10,11]

Portal oxygen saturation falls progressively with the decrease in hydrostatic pressures; however, it is subject also to great variations due to changes in rate of flow and the cellular demand for oxygen during rest and activity. (Chart 2)

Pathology of Atrophic Cirrhosis

The sequence of pathologic changes may be described categorically as follows: (1) A dissociation occurs between the portal and hepatic venous systems as a result of fibrosis and distortion, impeding and delimiting the free exit of blood from the portal sinusoids into the central vein. (2) With this interference, portal pressure increases and a more direct communication results between the hepatic artery and the portal venous branches. This observation is based upon perfusion experiments by the Herrick technic which show that whereas in the normal liver it takes 40 mm. of mercury in the hepatic artery to raise the portal venous pressure 1 mm., in the cirrhotic liver it requires only 6 mm. of mercury to

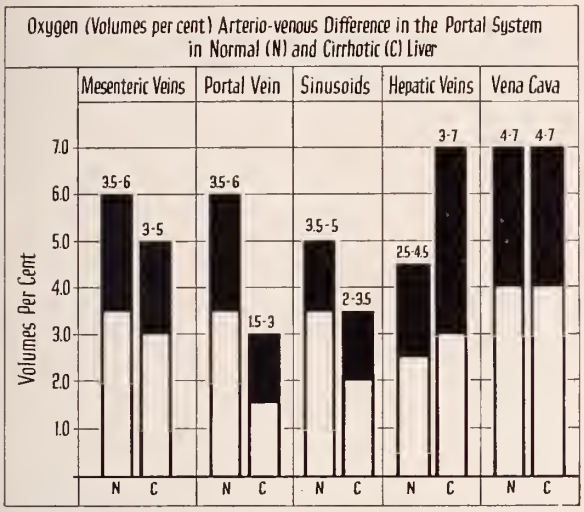

Chart 2—Oxygen arteriovenous difference in volumes per cent, in the normal and cirrhotic portal system. Although the oxygen content, capacity volume, and saturation index varied greatly under various conditions, the arteriovenous difference furnished reliable evidence of a constant increase in the normal from mesenteric to hepatic veins. The cirrhotic showed less arterio-portal-venous difference and more arterio-hepatic-venous difference. This was interpreted as indicating: (1) arterio-portal-venous shunts involving the entire splanchnic bed; and (2) oxygen desaturation due to sluggish flow, utilization by the ischemic liver, and diffusion through collaterals.

obtain the same result. (3) Portal pressure rises and collaterals form before the sinusoidal bed is reached. These collaterals go from areas of higher presssure to those of lower pressures; that is, from the portal vein with a high pressure of say 20 to 25 mm. of mercury to a low pressure in the vena cava of .5 mm. of mercury. Collaterals manifest themselves as esophageal, stomach, and mesenteric varices, hemorrhoids, enlarged retroperitoneal veins (Retzius), dilated veins on the abdomen (caput medusae) and venous enlargements throughout the portal system.

The increase in hydrostatic pressure within the portal vein is usually accompanied by a decrease in the osmotic pressure owing to the fact that the patient does not ingest sufficient protein and the liver fails to produce an adequate quantity of serum albumin. In addition, the amount of protein lost is increased if there is any degree of ascites. We formerly thought that this combination of transudation and exudation was partly due to a stagnant anoxemia. However, we have found since our first investigations that portal oxygen is actually higher in cirrhosis and falls only in the presence of an enormous accumulation of peritoneal fluid, then anoxemia definitely plays a role.[8] (4) Collaterals probably shunt most of the portal blood into the systemic venous circulation. This can be shown by perfusion through the cirrhotic liver in situ. When this is done it is difficult to obtain more than 13 to 15 per cent of the perfusant in the hepatic veins. (5) The hepatic artery continues to supply blood to the liver and is, in fact, the only source of supply when portal obstruction is far advanced, because the artery does not partake of the distortion process as quickly as do the venous components. Therefore, for a long time blood is shunted from hepatic artery to the portal system by way of the sinusoids and into the hepatic veins by arterial collaterals. (6) At this point, it would seem that there are three more or less abnormal arteriovenous communications; namely from the hepatic artery to the portal vein by way of the sinusoids; from the portal vein to the hepatic vein by way of collaterals which develop from newly formed capillaries; and from the hepatic artery to the hepatic veins. Although arteriovenous and veno-venous shunts are normally present, they are exaggerated in cirrhosis and constitute what might be termed a large cavernous hemangioma composed of internal and external Eck fistulae and involving the entire splanchnic bed including the abdominal wall, as demonstrated by the increased oxygen content in "caput medusae" collaterals.

Altered Circulation in Cirrhosis of the Liver

Pressures within the mesenteric veins and the portal vein rise in atrophic cirrhosis and blood flow is reduced. Although the changes are variable, our studies show that the pressure may reach 36 to 40 mm. of mercury in the mesenteric veins; 20 to 26 mm. in the portal; and 18 to 20 mm. in the sinusoids. Blood flow is reduced from about 1,530 cc. in the normal to about 380 cc. per minute in the cirrhotic.[14] Hydrostatic pressure varies inversely with the rate of flow, and therefore the portal venous radicles become dilated. As they become larger, the flow decreases and the lateral pressure increases. Finally, a vicious circle exists such as may be seen in varicose veins and in aneurysms. Pressure in the hepatic vein falls because a constriction has been placed along the course of the portal flow. Blood will move along to the lesser points of resistance through new collaterals, forming new veno-venous and arteriovenous shunts in addition to those normally present. Then the pressure within the hepatic veins will rise because the shunts deliver blood to them around the obstructed sinusoids, reaching the same pressure as in the sinusoids; that is, 20 to 22 mm. of mercury. The entire splanchnic area becomes a part of this varix which is easily demonstrable by the presence of many pulsating venules. Moreover, portal oxygen is increased, and the arterio-portal-venous difference is less, varying from 1.5 to 3 volumes per cent. This is also apparent in collaterals on the abdominal wall which average about 1.81 volumes per cent arteriovenous difference.[5,11] (Chart 2)

Oxygen studies on hepatic venous blood in cirrhosis reveal a fall in oxygen concentration and an increase in arterio-hepatic-venous difference which ranges from 3 to 7 volumes per cent.[10,12] This may be explained on the basis of increased oxygen uptake by the ischemic liver cells; sluggishness of flow through the liver and splanchnic bed permitting

more complete deoxygenation in the liver, spleen, and gastrointestinal tract; and diffusion of oxygenated blood through shunts into the systemic circulation. (Chart 2)

Traumatic Intrahepatic Vascular Communications

Abnormal arterial portal-venous and portal-hepato-venous shunts may result from extensive trauma to the liver. We have recently observed traumatic cirrhosis in a man, R. P., age 36, who had been injured nine months previously. The injury occurred while the patient was at work in a furniture factory. As a result of an explosion, a piece of metal penetrated and lacerated the liver. He was rushed to the hospital, and exploration disclosed a rent in the right lobe of the liver but no injury to the portahepatis and no other demonstrable lesions. The patient recovered without incident from this injury and remained well until January of 1952 when he came to Billings Hospital. At this time he had ascites and bleeding esophageal varices together with intractable diarrhea. (Figure 1) The stools contained bile but were liquid and foamy. There was no jaundice. He was explored, but definitive surgery could not be performed because of the patient's desperate condition. In spite of repeated blood and plasma transfusions, compression of the varices, vitamin K and other measures, the patient continued to bleed and therefore we were asked to see him. Operation was deemed mandatory. About 1,500 cc. of ascitic fluid was aspirated upon opening the abdomen. Portal pressure was 575 mm. of water, but biopsy of the liver did not disclose cirrhosis. The splenic and hepatic arteries were tied, and the operation hastily concluded because of a sudden fall in blood pressure which could not be adequately supported. The patient's immediate postoperative course was satisfactory. However, on the sixth day he became jaundiced and anuric. Death occurred on the eighth day from hepatic and renal insufficiency. At autopsy the ligature around the hepatic artery was found to be loose and the vessel unoccluded. The liver contained an area of portal cirrhosis which occupied a relatively small space in the right lobe. (Figure 2 and 3) Dr. Alfonso Abbatiello injected the liver vessels with diodrast for x-ray examination. This disclosed the following significant findings: a normal portal venous system except for some dilatation of the right main branch proximal to the site

Fig. 1—Mr. R. P., age 36. Infra-red photograph of abdomen showing distention due to ascites and prominent venous collaterals on the abdominal wall, nine months after liver injury.

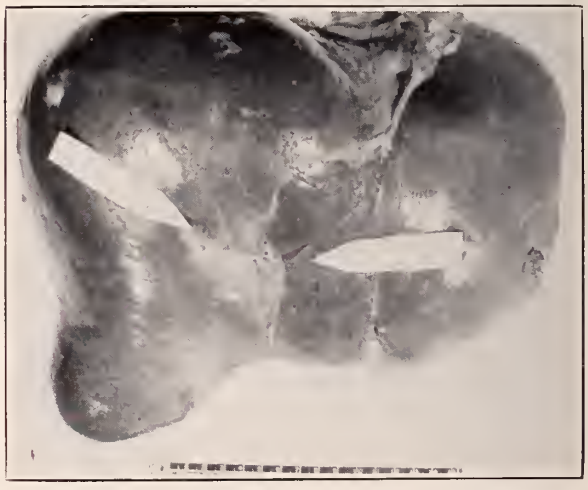

Fig. 2—Photograph of liver removed at autopsy. Arrow points to the site of fibrosis. The organ weighed 2,400 Gm. Note the relatively small area of scarring.

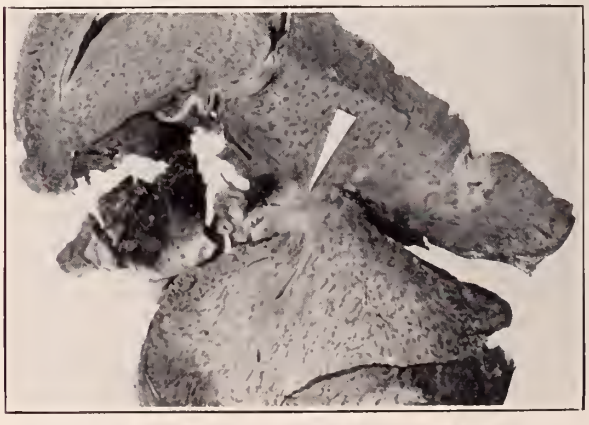

Fig. 3—Cross section through the region of traumatic cirrhosis.

Fig. 4—X-ray photograph of liver after injection of the portal vein with diodrast. The hepatic artery has been clamped with a hemostat to prevent loss of the opaque material. Note the absence of blunting, distortion, or occlusion of any portion of the portal tree. There is some dilatation proximal to the clot.

of injury. A blood clot was found in this branch, but it did not occlude the lumen. Indeed, no obstruction could be demonstrated in any portion of the portal tree. Perfusion through the portal vein is not accompanied by leakage from the hepatic artery in the normal or cirrhotic liver.[2] However, it was necessary to clamp the hepatic artery with a hemostat to prevent reflux in this case. (Figure 4) This was probably due to traumatic arteriovenous communications, although Dr. Marvin Solomon could not demonstrate these on serial sections. Hepatic vein injection also allowed leakage from the hepatic artery and portal vein. The hepatic venous tree was normal except for the site of injury. Here, a reflux of diodrast into the right portal branch was noted. (Figure 5)

Changes in hepatic circulation resulting from fibrosis probably account for two of the most lethal complications of portal cirrhosis; namely, ascites and bleeding varices. The former because it is a continuous plasmapheresis which is devastating, causing death in 68 per cent within 12 months and 17 per cent of the remainder within two years. The average duration of life following the first hemorrhage is 18 months; more than half of those who

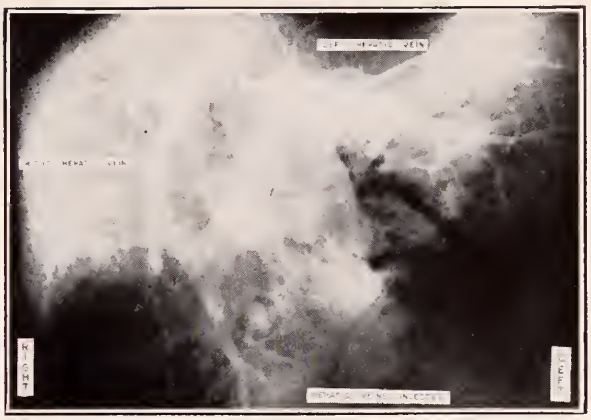

Fig. 5—X-ray photograph of liver after the diodrast had been squeezed out of the portal vein and the hepatic vein had been injected. This is a fairly normal venogram without evidence of obstruction except at the site of the injury. Here there is some diffusion into the portal vein.

survive will bleed again and their survival time will be 13 months. Of the latter group, one-fourth will have a third hemorrhage, and they will live about four months.

Treatment

The most effective treatment is prevention. However, until the etiology of cirrhosis is better understood this cannot be fully achieved. Great strides have been made in combating the known causes of the malady. A rational approach to the treatment of cirrhosis is to consider the basic functions of the liver and to spare the crippled organ of its work as much as possible.

In general the liver has six basic functions and in cirrhosis any or all of these may be seriously curtailed. Protein metabolism is so important to body economy that the liver guards this function to the very last. However, the decompensated liver cannot fulfill its role in the synthesis of amino acids into body proteins, the elaboration and formation of plasma proteins, the storing, synthesizing or deaminizing of protein. Carbohydrates are stored as glycogen in the normal liver. During cirrhosis the ingestion of a large quantity of simple carbohydrate is necessary in order that a source of glycogen for this organ may be available. Fat metabolism is impaired. Liver fat comes from the ingestion of fat, mobilization from fat depots, and synthesis of fat by the liver from carbohydrate and protein. Normally only 2 to 4 per cent of the liver weight is due to fat. As a result of excessive amounts of cholesterol, alcohol, or a deficiency in choline, the liver stores fat, thereby rendering itself more susceptible to the effects of hepatotoxins. Detoxification of toxins and bacteria is impaired in cirrhosis. Clotting time is inhibited because fibrinogen and prothrombin are not produced in adequate amounts. The production of bile is impaired, and bile that is produced is not readily secreted into bile canaliculi; consequently, jaundice may be an early and late symptom in cirrhosis.

Measures designed to combat cirrhosis and prevent lethal complications must be instituted early in the disease and continued until function is restored. The patient should be put at rest under strict dietary control. This includes a high protein, high carbohydrate, and low fat diet. Since the cirrhotic liver is unable to excrete sodium this cation should be restricted, and in addition cation-anion resins may be given because they aid in the removal of sodium through the gastrointestinal tract. This is important, particularly in the presence of edema or ascites because the kidney tubules are notoriously reluctant to eliminate sodium, causing a retention of this cation and with it a retention of water. This situation was formerly referred to as "cirrhotic nephrosis," and its explanation is still not entirely clear. The administration of choline and vitamin B and K aid in the digestion of fats and the production of substances which aid in clotting time. This type of management may curtail fatty infiltration and fatty degeneration which frequently occur in cirrhosis.

The liver may be spared the necessity of detoxifying bacterial endo and exotoxins by the use of antibiotics. Penicillin and streptomycin not only help to decrease the normal indigenous hepatic flora of bacteria but also the number of organisms in the blood stream. This is important as a prophylactic against liver necrosis should surgical diversion or alteration of its blood flow become necessary.

These measures are useful in the treatment of early cirrhosis, and also advanced portal cirrhosis, in conjunction with surgical measures designed to curtail the two most lethal complications—bleeding esophageal varices and ascites.

Bleeding from Esophageal Varices

The treatment for this complication depends upon three fundamental dicta: (1) arrest hemorrhage; (2) replace blood; and (3) prevent recurrence of hemorrhage. Bleeding may be controlled by indirect and direct measures. The former include vitamin K in large amounts and the use of coagulants such as protamine sulfate and blood transfusion. Direct control may be attempted by tamponade with inflatable tubes, injection of sclerosing agents, pressure around the esophagus with gelfoam, resection of the stomach and the varix area, and ligation or excision of the varices individually by transesophageal approach. Indeed, removal of the entire stomach has been advocated to stop the bleeding. Prevention of recurrence is all important to preserve life. Methods employed in addition to those just described are designed to decrease the volume of blood reaching the liver and reduce intrahepatic vascular pressure to permit a free flow through or around the organ. Splenectomy reduces the amount of blood reaching the liver by about 25 per cent. If the spleen is not greatly enlarged, it acts as a reservoir, relieving the liver of sudden changes in splanchnic volume. This is borne out clinically by the more favorable prognosis in cirrhosis without splenomegaly. The creation of a by-pass between the portal and systemic circulation such as splenorenal or portacaval shunts is said to divert much portal blood and reduce portal pressure. This same idea is embodied in the older operations of omentopexy (Talma) or scarification of the undersurface of the diaphragm.

Ligation of the arterial side of the large splanchnic cavernomatous transformation has been helpful in our hands. We have found experimentally and clinically that when the splenic, hepatic, and left gastric arteries are tied very close to the celiac axis, portal pressures fall and bleeding from esophageal varices may be curtailed. Ligation of the arterial side of an arteriovenous fistula in an extremity may cause gangrene because blood flows in two directions and will take a path of lesser resistance from arterial to venous collaterals, thereby neglecting the more resistant capillary bed. This does not seem to be the case in atrophic cirrhosis because arterial and venous blood flow in the same direction as in a large cavernous hemangioma. The competitive arterial force is eliminated by the ligations permitting more portal blood to enter the ischemic liver. The stomach apparently tolerates this procedure because of its unbounded collateral blood supply. The spleen is not usually removed, so that it may continue to act as a storage space for blood. These ligations are of no use in active bleeding because they are effective only after vascular adjustments have been made. Portal pressure does fall immediately, but, with an ischemic liver in an exsanguinated patient, further reduction of the inflow of blood to the liver is apt to be followed by "hepatic crisis" or insufficiency. Other contraindications to this procedure are as follows: severe persistent jaundice, systemic hypertension,[13] and cardiac inadequacy or congestive failure.

Ascites

The treatment of ascites due to portal hypertension has been unsatisfactory although many methods have been devised for its amelioration. In addition to the medical measures previously described, these patients require plasma proteins which cannot be synthesized by the crippled liver and which are being constantly depleted. Cation-anion resins help because they eliminate sodium by the bowel and thereby decrease the plasma sodium which retains water and increases ascites.

A great accumulation of ascitic fluid is not only extremely uncomfortable but also may interfere with vital functions sufficiently to endanger life. This becomes a vicious circle as follows: The fluid interferes with respiration producing anoxic anoxemia, and venous return to the right heart is impeded so that there is stagnation of blood in the abdomen. Thus the more highly oxygenated portal venous blood soon loses much of its oxygen when ascites accumulates under great pressure. This decreases the total amount of circulating blood volume and thereby increases anoxemia due to circulatory stag-

nation. Both processes tend to increase the formation of ascites because of the reduction in circulating blood volume causing a flow of intercellular fluid into the blood stream with hemodilution. The anoxemia in turn increases the trend toward more leakage. Ascites interferes with digestion and elimination, consequently appetite is lost. In fact, the anorexia is so pronounced that it is almost impossible to supply basic caloric requirements. This, in turn, depletes the protein reserve thereby decreasing the osmotic index of the blood and thus favoring more ascitic fluid formation. Lastly, sodium excretion is greatly impeded so that most cirrhotic patients have a retention not only of sodium but also of nitrogenous material and azotemia quickly develops. Therefore, the fluid must be removed from the peritoneal cavity, although it will soon re-form.

Paracentesis is a very old procedure but is not entirely innocuous. The sudden removal of a large amount of fluid may produce fatal shock. This results from the decrease in intra-abdominal pressure and rapid pooling of blood in the splanchnic bed. It is perhaps better to remove small quantities at frequent intervals rather than large amounts at any one time, not only because of the danger alluded to but also because it favors more rapid reformation. This is due chiefly to the loss of protein, thereby reducing osmotic pressure, and to the decrease in extravenous pressure enhancing the portal hydrostatic pressure. There have been attempts to form a more permanent type of drainage of the ascitic fluid from the peritoneal cavity by the use of subcutaneous channels made of glass or metal tubes, anastomosis of the peritoneum to the saphenous veins or the renal pelvis, the use of venous grafts from the peritoneal cavity to subcutaneous space, cannulas inserted in the peritoneal cavity and brought to the outside, and even resection of the parietal peritoneum. Also, methods have been devised to improve the collateral circulation such as omentopexy of Talma, anastomosis of the sigmoid veins to the saphenous veins, splenic vein to the left renal, or the portal vein to the inferior vena cava. Most of these methods have not been satisfactory, although some very favorable reports have been written about the use of splenorenal shunts. However, occasionally ascites will cease spontaneously and rarely simple exploration will ameliorate it.

We have found that ligation of the hepatic, splenic, and left gastric arteries when combined with dietary management, the use of cation-anion resins during the early postoperative period, and a low sodium intake of about 1½ Gm. per day has given us the best results.[8] More than half of our patients ultimately eat an unrestricted diet and are entirely free from ascites.

Summary

Disseminated fibrosis of the liver with atrophy commonly called portal or atrophic cirrhosis becomes a fatal disease when vascular decompensation occurs. At this time the combined efforts of physician and surgeon alike are necessary to stop the onward progress of the disease. We believe that improvement of hepatic circulation is mandatory if function is to be restored and lethal complications prevented or ameliorated. It is our hope that the procedures we have outlined will help accomplish the desired effects.

23 East Ohio Street.

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Can We Prevent Streptococcal Disease?

By CHARLES K. KINCAID, M. D.
Madisan

A LONG range program utilizing the case finding method was begun by the City Health Department of Madison, Wisconsin, to study the possibilities of preventing rheumatic fever and other complications or sequelae of beta-hemolytic streptococcal infections of the respiratory tract. This preliminary report summarizes the experience obtained during the first year. There is reason to believe that since effective antimicrobial agents are now abundantly available, the case finding method offers more hope for control of this disease than has been possible before.

Prevention of about 20 cases of rheumatic fever among patients who were treated early with penicillin for acute streptococcal tonsillitis or pharyngitis was recently estimated by Rammelkamp.[1] One case of rheumatic fever developed in the series of 978 treated patients compared to 23 cases of rheumatic fever which developed in a control series of 996 untreated patients. It is stated that since 40 to 50 per cent of individuals with beta-hemolytic streptococcal infections "fail to develop sufficient clinical symptoms to require medical attention, prophylaxis of rheumatic fever, otitis media, nephritis and other sequelae is a difficult problem."

A program designed to explore the possibilities of one approach to the problem was inaugurated in May of 1951 by the Health Department of Madison, a town of 96,000 population. Finding the mild and missed cases by making a throat culture on all school children who reported with a sore throat to the public health nurse at school, with subsequent referral of those whose cultures revealed the presence of beta-hemolytic streptococcus to the family physician for treatment, was the basic procedure.

During the first year, 340 or 21.8 per cent of 1,553 children with sore throat were found to harbor the beta-hemolytic streptococcus. During a four month period (December 1951 and January, February, and March 1952) groups and types were identified where possible at the University of Wisconsin Medical School.[2] Of these, one was group B, one group C, and 155 were group A. In descending order of frequency, the following types of group A were identified: 12, 6, 5, 11, 41, 26, 13, 31, 37, 3, 4, 11, and 42. This is approximately the characteristic picture for an endemic "year" in an open population where travel to and from other communities is unrestricted. The figure of 21 per cent of children with sore throat who were found to harbor beta-hemolytic streptococcus is comparable to the 24 per cent among 25,000 examined in the epidemic years 1934–1935 in a nearby metropolis.[3] This examination of 25,000 school children by culture during an epidemic period in one city supplies a figure of 24 per cent, which bears some authority, in view of the numbers involved. Other reports vary from 4 per cent among incoming inductees[4] to 10 per cent in normal civilian populations. This figure in normal civilian populations rarely rises over 40 per cent, even during epidemic times.[4] At Fort Bragg, 8 per cent of well soldiers harbored beta-hemolytic streptococci.[5]

At the time a child was sent home, a note went to the parent explaining the purpose of the throat swab with a recommendation to consult the family physician for treatment. The presence of beta streptococci in the culture was usually recognized the following day, if present. The physician's office was notified by telephone, and a visit was made by the nurse to the homes of cases reported as "positive" to explain the advantage of treatment of this infection. When the physician decided that active infection was present, the patient was designated a "case" and quarantined as required by law. Quarantine was lifted (as provided under the present state regulation) after two weeks, regardless of the treatment or response as gauged by culture methods. Advice relative to the terminal disinfection of the environment was given at the time of release from strict isolation.

Every member of the family group in which a child was found to have a beta streptococcal pharyngitis was asked to permit a throat swab and culture. There were 565 cultures obtained on family contacts of which 17.3 per cent were "positive" and referred to the family physician for treatment. If the "positive" family contact was symptom free, he was considered a carrier but not quarantined.

Near the end of the 12 month period, appropriate committees of the Dane County Medical Society critically evaluated the program to assist with the formulation of plans for the next year. The Dane County Medical Society devoted a meeting to the subject "Epidemiology and Treatment of Streptococcal Infections."[6] The various aspects considered were outlines for therapy, requirements for clearing streptococci from the premises, and the results of prophylaxis with small doses of penicillin among contacts.

Summary

School children with sore throat were examined by the culture method for case finding to study the possibilities for the prevention of beta-hemolytic streptococcal infections of the respiratory tract. Twenty-one per cent had a positive culture and were referred to the family physician for treatment. The

cooperation of the local practitioners and the studies of the county medical society were essential to the program. An evaluation of results in reducing rheumatic fever will not be available for some years. Subsequent studies will include "control" groups for comparison.

112 North Hamilton Street.

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SCHEDULE OF PROGRAMS OF THE "MARCH OF MEDICINE"

On April 1, 1952, the March of Medicine began its seventh consecutive year of radio broadcasting. The programs, which are tape recorded, feature Dr. R. C. Parkin discussing various health problems with a lay person who is called "Your Medical Reporter." At present 32 stations in Wisconsin, one in Michigan, and one in Minnesota are cooperating in presenting this program as a public service feature. The most recent schedule is as follows:

Station	*City*	*Time*	
WHBY	Appleton	Saturday	8:30 a.m.
*WHKW	Chilton	Saturday	10:30 a.m.
*WHWC	Colfax	Saturday	10:30 a.m.
*WHAD	Delafield	Saturday	10:30 a.m.
WEAU	Eau Claire	Saturday	1:30 p.m.
KFIZ	Fond du Lac	Saturday	8:30 a.m.
WBAY	Green Bay	Saturday	5:45 p.m.
*WHLA	Holmen	Saturday	10:30 a.m.
WJMS	Ironwood, Michigan	Saturday	8:15 a.m.
WCLO	Janesville	Saturday	6:30 p.m.
WLIP	Kenosha	Saturday	11:15 a.m.
WKBH	La Crosse	Saturday	11:00 a.m.
WLDY	Ladysmith	Saturday	11:00 a.m.
*WHA	Madison	Saturday	10:30 a.m.
WIBA	Madison	Saturday	9:00 a.m.
WOMT	Manitowoc	Saturday	8:30 a.m.
WMAM	Marinette	Saturday	11:15 a.m.
WDLB	Marshfield	Saturday	10:45 a.m.
WIGM	Medford	Saturday	11:30 a.m.
WEMP	Milwaukee	Sunday	8:30 a.m.
WEKZ	Monroe	Friday	2:00 p.m.
WNAM	Neenah	Wednesday	8:30 a.m.
WOSH	Oshkosh	Saturday	11:00 a.m.
WIBU	Poynette	Thursday	2:30 p.m.
KAAA	Red Wing, Minnesota	Monday	9:15 a.m.
WOBT	Rhinelander	Saturday	9:15 a.m.
*WHRM	Rib Mountain	Saturday	10:30 a.m.
WJMC	Rice Lake	Saturday	10:00 a.m.
WRCO	Richland Center	Wednesday	3:45 p.m.
WHBL	Sheboygan	Sunday	1:00 p.m.
*WLBL	Stevens Point	Saturday	10:30 a.m.
WDOR	Sturgeon Bay	Thursday	9:15 a.m.
WDSM	Superior	Sunday	10:00 a.m.
WSAU	Wausau	Monday	4:15 p.m.

* These stations also carry programs at 4:45 p.m. on Wednesdays on FM only.

Endometriosis*

By F. J. HOFMEISTER, M. D., F. A. C. S. and L. R. GRINNEY, M. D.
Milwaukee Racine

ENDOMETRIOSIS is a disease in which tissue morphologically identical with the endometrium of the uterus is found elsewhere. This endometrial tissue is surrounded by the same stroma and reacts in the same way that normal endometrium does, even to the decidual reaction of pregnancy.

Location

For practical purposes, endometriosis can be classified as internal and external. Internal endometriosis, also known as adenoma or adenomyosis, may consist of microscopic areas of invasion of the myometrium by endometrial glands, or of definite tumors resembling fibromata, but without capsules. Because the tumors lack capsules they are densely adherent and cause serious complications if the surgeon attempts to shell them out.

In external endometriosis the lesions are outside the uterine body; they may be on the peritoneal surfaces of the uterus, ovaries, pelvis, rectosigmoid, and many other areas. Figure 1 indicates the sites where ectopic endometrial tissue has been found. Table I enumerates in the order of frequency the location of external endometriosis in 460 patients at Milwaukee Hospital.

TABLE 1—*Incidence of Location of External Endometriosis in 460 Cases at Milwaukee Hospital.*

Location	Number	Per cent
Ovarian	270	79.6
One ovary	141	52.2
Both ovaries	129	47.8
Cul-de-sac	159	46.9
External uterus	122	35.9
External bowel	111	32.7
Uterosacral ligament	109	32.1
External bladder	39	11.5
One tube	7	2.1
Both tubes	17	5.0
Appendix	4	1.1
Cervix	11	3.2
Omentum	4	1.1
Ureter	2	0.6
Broad ligament	3	0.8
Round ligament	1	0.3

It is evident that the ovaries, cul-de-sac, uterus, bowel, and uterosacral ligaments are the leading sites.

The lesions appear as superficial cystic areas which vary from typical purple or dark blue, in the very active lesions, to red and brown in the older burned out lesions. These areas are surrounded by puckered adhesions whose density depends on the length of time the process has existed. In the ovary, endometriosis takes the form of the familiar chocolate cyst. Grossly, the ovarian lesion often is indistinguishable from a corpus luteum or simple cyst with hemorrhage into it. The surgeon must exercise his best judgment to avoid the unnecessary sacrifice of a normal structure. In all instances, microscopic study is required to verify the diagnosis.

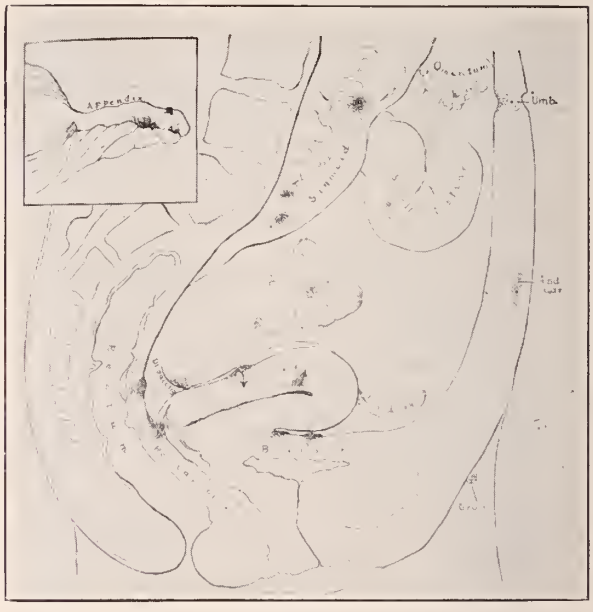

Figure 1.

Etiology

None should approach this subject without digesting the masterful treatise of Brooks Ranney,[2] "Etiology of Endometriosis," in which 25 theories of the origin of this disease are listed, beginning with the description of an adenoma by von Rokitansky in 1860. The very popular and epoch making "Theory of Sampson" in 1921 is discussed, and the "Celomic Metaplasia Theory" described by Waldeyer, Ivanoff, Meyer, Nowak, Heim, and Gruenwald is explained. It is interesting to note that 225 manuscripts written prior to 1946 were reviewed by Ranney. An additional 45 papers written since 1946 were reviewed for this paper. Endometriosis has long been recognized, but the interest is new, the suspicions have increased, and the diagnostic acumen has sharpened, hence the apparent increase in the incidence of endometriosis. According to Te Linde and Scott[3] of Baltimore, two theories have withstood the tests of time and investigation, (1) Sampson's Theory, and (2) the Celomic Metaplasia Theory.

The Nature of the Disease

Endometriosis is a self limiting disease burning out usually with the menopause. However, it is a

* From the department of obstetrics and gynecology, Milwaukee Hospital and Marquette University School of Medicine.

condition encountered in the early 20s and 30s, as evidenced in our series where 62.9 per cent of the cases of external endometriosis fell in this age group.

TABLE 2—*Age and Incidence in the Milwaukee Hospital Group.*

Age	Endometriosis No.	Endometriosis Per cent	Adenomyosis No.	Adenomyosis Per cent
10–19	1	0.3	0	0
20–29	77	23.1	2	1.1
30–39	133	39.8	31	19.0
40–49	105	31.4	92	54.7
50–59	18	5.4	39	23.2
60–69	0	0	4	2.3

During this period, with undisturbed ovarian function, the condition progresses at a rate of speed as yet undetermined. This is borne out by the fact that with pregnancy, if it can be accomplished, regression occurs. On the other hand, no one can prognosticate the period of remission, in spite of the quoted theoretical five year remission that is to be expected. We have seen symptoms recur as soon as the fourth to sixth period after pregnancy. However, in some cases symptoms have not recurred though the last pregnancy was more than five years ago. To all familiar with the nature of the disease, the absence of symptoms does not mean it is not progressing. All experienced with endometriosis realize that when involvement exceeds a certain degree, the characteristic periodic pains give way to either no pain, or constant pain, and finally bowel involvement and obstruction. No one can tell where it will stop once it is found. Consequently, endometriosis is a very dangerous condition.

Incidence in Private Practice

TABLE 3—*Incidence of Endometriosis in Abdominal Operations Performed at Milwaukee Hospital.*

Year	Operations	Endometriosis	
1946	960	135	14.4%
1947	924	132	14.7%
1948	923	101	10.9%
1949	855	180	21.0%
1950	931	179	19.2%

TABLE 4—*Internal and External Endometriosis in the 460 Cases Analyzed.*

Year	Int.	Ext.	Int. and Ext.	Total
1948	0	93	8	101
1949	65	103	12	180
1950	56	96	27	179
	121	292	47	460

As seen in tables 3 and 4, there has been a decided increase in the incidence of endometriosis in 1949 and 1950. The analysis is made only on the last three years. It is interesting to note the absence of internal endometriosis in 1948. Of interest and also in keeping with the findings in Boston and Baltimore is the fact that there are no cases of endometriosis recorded at the Milwaukee County Hospital for the year of 1948 and only 5 cases in 1950. Why? Is it diet? Is it the social status? Can it be the greater incidence of early childbirth in patients who use the county facilities?

Diagnosis

TABLE 5—*Incidence of Pre-operative Diagnosis in Hospital Series.*

External Endometriosis	51%
Internal Endometriosis	8%
Internal and External	21%

TABLE 6—*Incidence of Pre-operative Diagnosis in Private Series.*

	Cases	
Total External Endometriosis	79	
Preoperatively Diagnosed	59	74.6%
Postoperatively Diagnosed	20	
Total Internal Endometriosis	17	
Preoperatively Diagnosed	2	11.7%
Postoperatively Diagnosed	15	

Endometriosis, contrary to the opinion of some, can be diagnosed with a great degree of accuracy. Table 5 shows that in the 460 cases reviewed, external endometriosis was preoperatively diagnosed 51 per cent of the time, internal endometriosis 8 per cent, and the combination 21 per cent. Table 6 reveals that in 93 of these cases, which we were further able to analyze, the preoperative diagnosis of external endometriosis was made 59 times out of a possible 79 times or 74.6 per cent. Internal endometriosis, on the other hand, was only diagnosed preoperatively 11.7 per cent of the time. How is this diagnosis made? A complete knowledge of the symptoms is essential.

TABLE 7—*Predominant Symptoms of External Endometriosis.*

Dysmenorrhea	54.2%
Abnormal bleeding	28.3%
Backache	26.2%
Sterility	6.7%
Dyspareunia	5.9%
Bowel symptoms	3.8%
Bladder symptoms	3.2%
Prolapse, vomiting, recurrent abortion, abdominal swelling	3.0%

TABLE 8—*Predominant Symptoms of Internal Endometriosis.*

Abnormal bleeding	48.7%
Dysmenorrhea	19.8%
Abdominal enlargement	11.0%
Prolapse	9.9%
Backache	9.0%
Urinary complaints	2.4%
Leukorrhea	2.4%
Headache	.8%

Tables 7 and 8 show the symptoms presented. The external type of endometriosis has increasing

dysmenorrhea, abnormal bleeding, and backache as the prominent symptoms. Abnormal bleeding in the form of menorrhagia takes the lead in the internal type. Constant inter-menstrual lower abdominal pain cannot be disregarded as a symptom of endometriosis. Left lower quadrant pain in the patient over 40 is highly suggestive. Diverticulitis must always be considered. It is of more than incidental interest that in the over-all series retroversion was present in 27.8 per cent of the patients and in 29 per cent of our patients.

What are the findings of examination and how are they recognized? The secret lies in the drawing seen in figure 2. Rectovaginal abdominal examination is the answer.

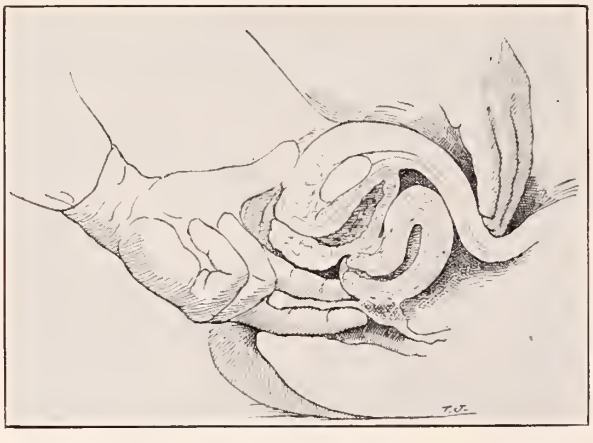

Figure 2.

Only with this type of examination can the uterosacrals, the posterior uterus, and the ovarian areas be completely palpated. Examination must be done frequently at well chosen times of the cycle. The day menstruation starts, after menstruation stops, and at the mid-cycle are preferred by us. The bladder must be completely empty, and the patient is instructed to take an enema a short time before coming to be examined.

Conditions associated with the endometriosis often overshadow the endometriosis. A list of these is seen in table 9.

TABLE 9—*Incidence of Associated Pathology.*

Fibromyoma	43.9%
Adhesions	42.7%
Chronic cervicitis	42.0%
Retroversion	27.8%
Ovarian tumors	16.7%
Endometrial hyperplasia	9.5%
Ectopic pregnancy	4.3%
Salpingitis	3.4%
Carcinoma	3.4%
Uterine pregnancy	1.0%
Bicornate uterus	0.6%
Pelvic Inflammation	0.2%

Of mounting importance is the incidence of malignancy associated with this condition. Dockerty of the Mayo Clinic and Hertig of Boston[8] are impressed with the incidence of adenoacanthoma in ovarian endometriomata. We have had one such case but not in this series. In the over-all series, the incidence of malignancy was 3.4 per cent, in our series it was 2.1 per cent.

TABLE 10—*Incidence of Malignancy.*

			Private Series	
Adenocarcinoma—Endometrium	7			
Squamous Cell Carcinoma—Cervix	2			
Carcinoma-in situ—Cervical stump	1			
Granulosa Cell Carcinoma	1			
Papillary Serous Cyst, Adenocarcinoma—Ovary (pre-existing Endometrial cyst)	1			
Adenocarcinoma—Endometrium			2	
Papillary Serous Cyst Adenocarcinoma—Ovary	1			
	14	3.4%	2	2.1%

Treatment

What place has the medical regime? We use it only for palliation of pain and where a surgical procedure is refused, or while temporizing and waiting for the scant chance of pregnancy to occur. We agree with Te Linde and Scott[10] who state, "There is insufficient evidence at present to permit anyone to be dogmatic regarding the effect of stilbestrol and testosterone on endometriosis. Hence, hormonal therapy should be used only for those patients requiring treatment who refuse surgery." With the use of stilbestrol, we and others[11] have encountered several instances of such uncontrollable bleeding that hospitalization and curettage was necessary. It is believed by some that the menopausal symptoms in these patients can safely be combatted with routine estrogen therapy. A contrary opinion is expressed by Allen and Priest [12] who have a patient with a rectal endometrioma which can be made to bleed at will, by the administration of estrogen.

The treatment, therefore, lies in surgery, carefully planned and carefully executed, for the surgery of endometriosis is difficult, dangerous, and often nerve wracking. It is sometimes called "piddling" surgery by the general surgeon. This well planned "piddling" surgery pays off in emotionally stable women, and often childbirth in the patient who was considered barren. Gynecologists[13,14] all agree that an almost infinitesimally small piece of preserved ovary will result in normal menstruation and childbirth.

TABLE 11—*Types of Surgery Done in the Over-all Series.*

Conservative 129	38.1%	**Semi-radical** 97	28.6%
Excision or cautery	64.3%	Total hysterectomy and 1 salpingo-oophorectomy	43.2%
Suspension	62.0%	Subtotal hysterectomy and 1 salpingo-oophorectomy	37.0%
Ovarian resection	59.7%	Total hysterectomy only	9.2%
Salpingo-oophorectomy	47.5%	Subtotal hysterectomy only	8.2%
Presacral neurectomy	10.8%	Vaginal hysterectomy only	2.0%
Myomectomy	8.5%		
Ovarian neurectomy	5.4%		
Radical 113	33.3%		
Total hysterectomy and bilateral salpingo-oophorectomy	57.5%		
Subtotal hysterectomy and bilateral salpingo-oophorectomy	36.2%		
Bilateral oophorectomy	2.0%		

As seen in Table 11, conservative surgery was instituted in 38.1 per cent of the cases. Semi-conservative surgery was used in 28.6 per cent of the cases. The question must be asked, "When are you semi-conservative?" When I tried this method, I created the conditions which necessitated secondary operations or x-ray therapy or both. It is in this situation x-ray therapy alone finds its place. We have often found after deep therapy that a painful scarred area remains which is relieved only after removal. To treat a condition like this primarily with x-ray requires more fortitude than we possess. Carcinoma or diverticulitis can be mistaken for endometriosis. Radical surgery was used in 33.3 per cent of the cases.

TABLE 12—*Types of Surgery Done in the Private Series.*

External Endometriosis	79	
Conservative	50	63.5%
Radical	20	36.5%
Internal Endometriosis		
Conservative	0	
Radical	17	100%

Table 12 reveals that in the cases that were ours, conservative surgery was performed in 50 out of 79 cases of the external type, an incidence of 63.2 per cent. All internal types were treated radically. It should be noted that 4 cases were re-operated, 3 from a previous series and 1 from this series. This is an incidence of 4.3 per cent, and 3 of these repeat operations had previous x-ray therapy.

No results are available for the entire series, but the statistics relative to fertility are interesting. In our own cases, there were 84 patients who had had from one to five pregnancies before the occurrence of symptoms and the operation. There were 14 infertility problems; seven of these conceived after conservative surgery. Infertility to us means at least one and one-half to two years of trial with all fertility studies normal except for the presence of endometriosis. Two of the pregnancies ended in abortion, and at least one patient is pregnant a second time.

Conclusions

1. Endometriosis is a condition that can be diagnosed preoperatively in one-half to three-fourths of the patients. However, sufficient effort must be made, a careful routine followed, and, above all, the examiner must be endometriosis conscious.

2. The treatment of choice remains surgical. The type of surgery depends upon the age, parity, and the status of the condition. Conservative surgery, though difficult and dangerous, holds much promise.

3. The incidence of malignancy is appreciable.

4. Though pathologically benign, endometriosis clinically behaves like a malignancy.

(F.J.H.) 2212 West State Street.

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ANNOUNCEMENT FROM THE AMERICAN COLLEGE OF CHEST PHYSICIANS

The nineteenth annual meeting of the American College of Chest Physicians will be held at the Hotel New Yorker, New York City, May 28–31, 1953. Physicians who wish to present papers at the meeting should submit titles and abstracts to Dr. Arthur M. Olsen, Chairman, Committee on Scientific Program, American College of Chest Physicians, Mayo Clinic, Rochester, Minnesota.

Conservation of Blood

By TIBOR J. GREENWALT, M. D.
Milwaukee

BLOOD, not unlike petroleum, is a limited natural resource. The total estimated population of the United States was 154,853,000 on Sept. 1, 1951. At the present time only individuals between the ages of 18 and 60 are permitted to donate blood. These comprise approximately 86,434,000 of our population. Eight per cent of applications for insurance are rejected by insurance carriers; another 16 per cent are rated for physical or occupational reasons. From this we can safely assume that approximately 10 per cent of the population who qualify as to age would never volunteer to give blood. This reduces our potential donor population to 77,790,000. Approximately 20 per cent of donors are rejected at the time they offer to donate, leaving us with 62,232,000 individuals who might be expected to furnish our reservoir of blood. This may sound like a huge potential, but how many are actually willing to participate?

It has been quite a problem to meet the quota of 3,000,000 pints set by the Department of Defense for a one year period, even though this represents only one donation a year by less than 2 per cent of our population. In a period of grave national crisis represented by World War II, the American National Red Cross collected only 13,000,000 pints of blood in a four and one-half year period. Many individuals gave on numerous occasions so that the 13,000,000 pints represent fewer than 13,000,000 individuals. Many millions of pints of blood and plasma would be required in a very short space of time in case of a surprise large scale atomic attack on our country. How many individuals could be induced to donate their blood at such a time? I strongly suspect that something more than persuasion will be required to collect all of the blood needed for all purposes. The best we can do right now is to see that large stockpiles of plasma are accumulated. Every pint of blood that is not transfused unnecessarily could be converted into plasma. We should, therefore, use blood wisely and only when it is definitely indicated.

There is no substitute for plasma which can be recommended for use in preference to plasma if plasma is available. A number of macromolecular materials hold promise as possible supplements to our inadequate plasma supply in case of great disaster. These substances are referred to as plasma extenders or plasma expanders. During World War I a 6 per cent solution of gum acacia gained some popularity. Its use is now no longer recommended because it is stored in the tissues, especially in the liver. The value and relative safety of gelatin, oxypolygelatin (OPG), dextran, polyvinylpyrrolidone (PVP), globin, and okra are being investigated. Isinglass (fish gelatin), pectin, methylcellulose, colloidin, and degraded bovine albumin have all been suggested and investigated experimentally as possible plasma substitutes. The toxicity, metabolism and storage, and the efficiency of the plasma expanders are now being studied intensively by various groups in this country. None of them seems to be a completely acceptable substitute for plasma. Therefore, it seems wise for us to build up our stockpiles of plasma, supplementing them with one or more of the more acceptable plasma expanders. At the present time it is recommended that the plasma extenders be used only for investigative purposes, or, in case plasma is not available, in grave emergencies.

It is apparent to those of us who are close to this problem that a great deal of blood is being wasted because of incomplete understanding of indications and technical problems.

Many patients are given unnecessary transfusions. In some instances patients are being exposed to the ever present dangers of blood transfusions when they could be treated more efficiently and safely by other accepted forms of therapy. For example, let us take the patient with a severe iron deficiency anemia, usually due to chronic blood loss. I have seen such patients admitted to a hospital with a hemoglobin level of 4 or 5 Gm. per cent and transfused with 8 to 10 pints of blood before oral iron therapy was even considered. Certainly blood transfusions are wasted in such cases. Oral iron medication or, in very rare instances, intravenous iron therapy will do the job efficiently and safely. Patients with macrocytic anemias, especially pernicious anemia, are frequently abused in this way. Those macrocytic anemias associated with a megaloblastic bone marrow picture will respond very satisfactorily to therapy with liver, vitamin B_{12}, or folic acid, as indicated. It is only in very rare instances that a transfusion or two is indicated.

It must be emphasized that symptoms caused by anemia will very rarely appear before the hemoglobin level has dropped to 7 or 8 Gm. per cent. One cannot explain the symptoms (especially of neurotic females) on the basis of 9, 10, or 11 Gm. per cent of hemoglobin. It is not uncommon to encounter hemoglobin levels of 11 and 12 Gm. per cent during pregnancy. This is usually explainable on the basis of hydremia or the expansion of the plasma volume during pregnancy. The diagnosis of anemia during pregnancy is not made unless the hemoglobin level drops under 11 Gm. Even then, of course, transfusion is not indicated.

The whole problem boils down to the careful differential diagnosis of anemia. Every case of anemia

should be carefully studied, and the nature of the anemia determined. The appropriate form of therapy should then be administered and transfusions reserved for those cases with the aregenerative forms of anemia. The large group of patients with chronic normocytic normochromic anemia, which is frequently associated with chronic infectious disease, chronic renal disease, chronic liver disease, hypofunction of the thyroid, and malignancy, will usually not respond to any of the presently known forms of therapy. In these cases, treatment should be directed to the underlying condition. Transfusions will result in only temporary benefit because of the limited survival of the transfused cells. It is usually not necessary to transfuse such patients unless the hemoglobin level falls below 10 Gm. per cent, and then ordinarily one should not attempt to raise the blood level higher than this by transfusion. I have seen many such patients transfused until their red blood cell counts and hemoglobin levels approached what is considered to be 100 per cent of normal. In occasional instances transfusion polycythemia is produced.

When blood becomes readily available, it has become customary for some surgeons to give transfusions preoperatively to almost all their patients. While in some cases this is desirable, in many instances it is not necessary and perhaps even contraindicated.

The ordering of whole blood has become almost a conditioned reflex when ordering transfusions. Use of whole blood routinely for all cases is as outmoded as the "shotgun" prescription. It is true that patients who are suffering the loss of whole blood should be given whole blood transfusions. Many patients, however, require only the red cells and do better if only the red cells are administered. In other situations only plasma is indicated.

We advocate the use of red cell mass transfusions whenever they are indicated. Red cell mass consists of the sedimented cells from a pint of blood from which the supernatant plasma has been removed by aspiration into another vacuum container. The volume of a whole unit of red cell mass varies between 300 and 400 cc., depending on the degree to which the red cells have sedimented while the blood has been in the refrigerator. The hematocrit of a red cell mass preparation varies between 60 and 65 per cent. It is administered in the same manner as a transfusion and will flow readily through an ordinary needle. The same precautions of careful crossmatching must be observed as with whole blood transfusions.

Red cell mass transfusions are indicated in uncomplicated anemias not associated with hypoproteinemia when transfusion is indicated. They are particularly indicated in patients with limitation of cardiac reserve, hypertension, and nephritis. In such patients they are advantageous because the total volume of fluid administered intravenously, in order to accomplish the same effect as the transfusion of a whole pint of blood, is reduced by practically half.[1,2] By removing the plasma, the sodium content of the transfusion is greatly reduced. In a recent study it was shown that the average amount of sodium eliminated by removing the plasma was 967 mg.[3] Red cell mass can be used effectively in preparing anemic patients for surgery in cases where the blood volume is normal. It must be emphasized that red cell mass is not as effective as whole blood or plasma in the presence of shock. Its use is to be avoided in the presence of shock. Red cell mass has been found by the author to be especially useful in pediatric transfusions. There are very few indications in pediatric transfusion practice for anything other than red cell mass. It makes possible the rapid elevation of the red cell count and hemoglobin values with safe volumes. It is more efficient and effective than whole blood when used in replacement transfusions for hemolytic disease of the newborn.

Red cell mass should be clearly distinguished from packed red blood cells and washed red cells and also from resuspended red blood cells. The term packed red blood cells indicates that the blood has been centrifuged prior to the removal of the plasma. This preparation offers no particular advantages over red cell mass and is technically more difficult to prepare. In washed red blood cell preparations the red cells have been washed at least three times with saline to remove most of the plasma proteins. Ordinarily such preparations are reconstituted with saline or glucose and saline solutions to the original volume of the whole blood. Resuspended red blood cells consist of red cell mass or packed red cell preparations which have been either partly or completely reconstituted with saline or glucose and saline preparations. Red cell mass preparations are simpler to prepare than any of these other preparations and have the advantages of smaller volume and lower content of sodium.

Not the least advantage of the use of red cell mass preparations is the fact that they lead to the more efficient use of each pint of blood. The patient who needs only the oxygen-carrying capacity of red cells receives them, whereas the plasma is salvaged and can be used in those situations where only plasma is indicated.

Plasma has lost a great deal in popularity because of the "bugbear" of homologous serum jaundice. It deserves somewhat more widespread use than it is enjoying at the present time. If the donors are carefully screened and the necessary precautions taken in the preparation of the plasma, this danger is greatly minimized. There is evidence to show that liquid plasma is safer than either frozen or dried plasma in this regard.[4] While freezing or drying plasma in the fresh state tends to preserve some of the labile constitutents, it also furnishes the ideal conditions for preservation of the agent of homologous serum hepatitis. In liquid plasma, which must be stored at room temperature, the conditions for the survival of the viral agent are not as suitable.

Plasma is indicated in states of shock associated with hemoconcentration. This occurs with extensive burns, extreme dehydration associated with severe vomiting and/or diarrhea, and neurogenic shock. It is also recommended for its nutritional value in conditions where the metabolism of the proteins is impaired, such as in severe liver diseases and in the nephrotic or the nephritic-nephrotic syndromes. It may also be used as an adjunct in severe nutritional problems.

A considerable amount of blood is wasted annually because of the lack of familiarity of the transfusionist with the equipment. The various manufacturers of blood containers have incorporated certain features into the stoppers of their bottles which are advantageous to the user if he is familiar with them. It is most important to be completely familiar with the construction of the stopper and the rest of the equipment. This familiarity is easily developed by reading the literature furnished by the commercial firm or, in many instances, the label on the blood container. This is a simple matter, but it is amazing how infrequently it is done. It takes only a fraction of a minute and has to be done only once.

It is most important that at least a 15 gauge needle be used as an air release. Frequently one sees 18, 19, 20 and even 22 gauge needles used for this purpose. No wonder the operator is annoyed by the slowness with which the blood runs. It is important also that the filter housing be filled with solution or blood to just above the level of the filter. If this is not done, only a fraction of the effective filtering surface of the filter is used and it becomes plugged more rapidly. In starting a transfusion an 18 guage needle should be used whenever possible. Strangely enough it is usually easier to insert a larger rather than a smaller needle into the patient's vein.

One frequently hears the complaint that bank blood runs too slowly. This is frequently the case because the sedimented red blood cells have not been adequately mixed with the supernatant plasma prior to starting the transfusion. During storage in the refrigerator the red blood cells settle to form a viscous mass which will not flow readily until it has been adequately agitated. It is a characteristic of refrigerated blood and plasma that fibrin separates out in small shreds and masses. In some instances, these tend to plug the filter in the recipient set. This difficulty can be largely eliminated if the blood flask is taped to the shaft of the standard at an angle with the outlet into the recipient set uppermost (Figure 1). In this manner, the fibrin flecks and small clots settle away from the outlet and do not get into the filter housing.

There is too much tendency, especially on the part of members of house staffs, to give up too easily in attempting to start a transfusion. I have all too frequently heard the remark, "This blood won't run," when the needle was not in the patient's vein or even when the air release needle has not been

Fig. 1—With bottle taped in this position, having outlet orifice uppermost, difficulty due to fibrin flecks and small clots is minimized. (Photography by Medical Illustration Laboratory, V. A., Wood, Wisconsin)

inserted in its proper place. In occasional instances where there is difficulty in getting the blood to flow properly, it may be necessary to use a special slotted stainer cannula in the recipient set (Figure 2). All institutions will find it worth while to keep one or two such specially prepared sets on hand for use in these instances.

A considerable amount of blood is wasted prior to issue by the laboratory because of lack of attention to certain details which seem relatively unimportant. This is especially so when the blood is obtained from some outside source. Great attention should be paid to the outdating time of any pint of blood which is withdrawn from the refrigerator. It seems logical and simple enough to use the older blood first. Apparently this is frequently not done. As a result, the freshest blood on hand is used first, and the older blood reaches its outdating period and in many instances is completely wasted.

When blood is easily available and especially when it is supplied by a central blood bank, there is a tendency on the part of many physicians to order a great deal more for a particular patient than is actually necessary. I have had the occasion to run into situations where a physician insisted that as many as 14 pints of blood be delivered to the ward for a particular patient. This is extremely illogical because ordinarily it will take many hours to transfuse a patient with 14 pints of blood. The storage facilities on the ward are not as adequate as they are in the laboratory. Some of the blood may be allowed to sit at room temperature for long periods

Fig. 2—This slotted strainer set is useful when blood does not flow satisfactorily. The large slotted cannula is inserted up to its base into the outlet of the blood bottle. (Photography by Medical Illustration Laboratory, V. A., Wood, Wisconsin)

of time and then, if it is not used, it becomes unsuitable for any other purpose.

A certain amount of waste results in using O Rh negative blood for any patient when in doubt. If this kind of practice is abused, the balance of blood stored at the blood bank is upset. Great hardship is experienced in obtaining O Rh negative donors. Meanwhile, the group specific blood, which the patient should have received in the first place, outdates, and may be totally wasted. Whenever and wherever possible, group specific and Rh specific blood should be used. In this manner the distribution of blood groups and Rh types in the blood used will tend to parallel that in the blood collected, and less blood will outdate.

Who is to blame for all this wastage and misuse of blood? Every person from the doctor who orders a transfusion, the technician who cross-matches the blood, the nurse who makes the preparations for the transfusion, to the intern or resident who inserts the needle has at some time or other been at fault. Ordering and administering a transfusion has become such a simple matter that many of us forget that there is a right and wrong way of doing it. Doing a venipuncture seems like such a simple and menial task to many of us that we never bother to learn the proper method of doing one. I will quote briefly from Doctor Stokes'[5] book to indicate how a proper venipuncture should be done:

> "Unlike golf, the intravenous injection has no official stance, no professionally authoritative technic of drive and putt. An average degree of proficiency in intravenous work can be acquired with reasonable rapidity, provided some thought is given to a definite, reasoned-out system of movements. That this is seldom undertaken is suggested by the really surprising posturings one occasionally observes through the glass windows of operating and treatment rooms. . . . The essential items in the correct technical approach involve:
>
> 1. Satisfactory choice of needle.
> 2. The position of the arm . . . Much trouble arises from failure to extend the arm completely.
> 3. A proper application of the tourniquet.
> 4. The identification and preparation of the vein.
> 5. The four-point technic of entry.
>
> The first step consists in the fixation of the vein with the left hand.
>
> In the second step, the needle, whether guided by the fingers or the syringe, is entered on the flat in the direction of the long axis of the vein.
>
> The third step consists in the puncture of the upper surface of the vein wall. With the point of the needle just visible as a slight elevation under the skin, advance the needle approximately ½ to 1 cm. so that it is visible as a ridge above the upper surface of the vein wall. Then very slightly raise the butt of the needle or the syringe coincidentally with downward pressure of the point upon the roof of the vein. A slight advance of a properly sharpened needle then punctures the vein wall, and the moment this occurs the syringe or needle butt is again dropped toward the forearm, flattening the needle out along the long axis of the vein, to prevent puncturing the far side of the vessel. The needle is then pushed up the vein for a distance of approximately 1 cm. in order to avoid any possibility of leakage under the bevel. . . .
>
> The fourth step is the demonstration of the fact that the needle is completely within the lumen of the vein and entirely free."

With a little more thoughtfulness in ordering and handling blood, these weaknesses in our system can be readily corrected. Every bottle of blood should be treated with a great deal of respect. Volunteer

donors are all wonderful people and are justly proud of that pint which they gave. Handle with care!

763 North Eighteenth Street.

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UROLOGY ESSAY CONTEST ANNOUNCED

The American Urological Association offers an annual award of $1,000 (first prize of $500, second prize $300, and third prize $200) for essays on the result of some clinical or laboratory research in urology. Competition shall be limited to urologists who have been in such specific practice for not more than five years and to men in training to become urologists.

The first prize essay will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Hotel Jefferson, St. Louis, Missouri, May 11–14, 1953.

For full particulars write the Executive Secretary, William P. Didusch, 1120 North Charles Street, Baltimore, Maryland. Essays must be in his hands before January 15, 1953.

THE AMERICAN DERMATOLOGICAL ASSOCIATION ANNUAL PRIZE ESSAY CONTEST

The American Dermatological Association is again offering a prize of $300 for the best essay submitted for original work, not previously published, relative to some fundamental aspect of dermatology or syphilology. The purpose of this contest is to stimulate investigators to original work in these fields.

Manuscripts typed in English with double spacing and ample margins as for publication, together with illustrations, charts, and tables, all of which must be in *triplicate*, are to be submitted not later than January 1, 1953. The manuscripts should be sent to Dr. Louis A. Brunsting, Secretary, American Dermatological Association, 102–110 Second Avenue, Southwest, Rochester, Minnesota. Those which are incomplete in any of the above respects will not be considered.

Competition in this prize contest is open to scientists generally, not necessarily to physicians.

The award will be made by a committee of judges selected to pass on the essays by the Research Aid Committee of the American Dermatological Association and the decision of the judges shall be final. The essays are judged on the following considerations: (1) originality of ideas; (2) potential importance of the work; (3) experimental methods and use of controls; (4) evaluation of results; (5) clarity of presentation. This contest is planned as an annual one, but if in any year, at the discretion of the Committee and judges, no paper worthy of a prize is offered, the award may be omitted.

The prize winning candidate may be invited to present his paper before the annual meeting of the American Dermatological Association with expenses paid in addition to the $300 prize. Further information regarding this essay contest may be obtained by writing to the Secretary of the American Dermatological Association.

The next annual meeting of the American Dermatological Association will be held June 9–13, 1953, at The Lake Placid Club, Essex County, New York.

Industrial Dermatoses

By HARRY R. FOERSTER, M. D.
Milwaukee

THE SECOND OF TWO PARTS

Diagnosis of Occupational Dermatitis

THE recognition of the occupational origin of a dermatitis venenata may be quite obvious in some cases but very difficult to determine in others. The importance of establishing a correct diagnosis early in the course of the dermatitis cannot be overemphasized since it involves correct and adequate treatment and also determines questions of liability and disability and changes of work. Both diagnosis and treatment require adequate dermatologic knowledge and often the services of a dermatologist. Too frequently the latter is called too late, when an accurate diagnosis cannot be made with certainty, and when disabling dermatitis has already resulted.

The responsible physician should be familiar with the diagnosis and interpretations of primary irritants and sensitizers, and he should resort to use of the fundamental criteria for the diagnosis of occupational dermatoses because of the legal aspects of these cases. This applies to the dermatologist and to the industrial physician as well as to the doctor in general practice. Too much responsibility is involved to justify diagnosis based on impressions and alleged clinical experience.

The importance of recognizing certain fundamentals for the differentiation of occupational from non-occupational dermatitis was first stressed by C. Guy Lane in 1923 and basic rules for diagnosis were first enumerated by Sulzberger in 1936. The Committees on Industrial Dermatoses of the American Medical Association and the American Dermatological Association compiled the following "Criteria for Diagnosis" which were accepted by the American Medical Association Council on Industrial Health and were published in the *Journal of the American Medical Association*, February 21, 1942.

The use of these criteria routinely in practice and particularly in cases that may come before Industrial Boards or Commissions is urged as a basis for reducing errors in the determination of causes and in the interpretation of questions of liability.

"1. The dermatologic diagnosis is that of a dermatosis in which the role of an occupational causal factor (major or contributory) has at some previous time been established beyond reasonable doubt;

"2. The individual has been working in contact with an agent known to have produced similar changes in the skin;

"3. The time relationship between exposure to the agent and the onset of the dermatitis is correct for that particular agent and that particular abnormality of the skin;

"4. The site of the onset of the skin disease and the site of maximum involvement are consistent with the site of maximum exposure.

"5. The lesions present are consistent with those known to have followed the reputed exposure or trauma;

"6. The individual is employed in an occupation in which similar cases have previously occurred;

"7. Some of the individual's fellow workers using the same agent are known by the examiner to have similar manifestations due to the same cause;

"8. So far as the examiner can ascertain there has been no exposure outside occupation which could be implicated;

"9. If the diagnosis is dermatitis, the following items are important:

"(a) The evidence of previous attacks coming after exposure to an agent followed by improvement and clearing after cessation of exposure constitutes most convincing evidence of the occupational factor as a cause;

"(b) The results of patch tests performed and interpreted by competent dermatologists corroborate the findings of the history and examination in the majority of cases:

"It is realized that these criteria are difficult of application in certain groups of cases, such as:

"1. Sensitization cases.

"2. Cases in which there is accentuation of existing skin diseases by occupational factors.

"3. Cases in which there are supervening complications of other dermatoses and occupational dermatoses.

"4. Cases in which much time has elapsed between the development of the dermatosis and the examination.

"5. Cases which have been overtreated.

"6. Cases in which an accurate history is not obtainable."

The Patch Test

The patch test is a well recognized diagnostic aid, but it must be emphasized that it is only an aid. Its chief value is for the recognition of allergenic sensitivity. In doubtful cases control tests should be performed. When patch tests are made with possible primary irritants, the material should be adequately diluted with an appropriate vehicle or the chemical should be applied uncovered and for a limited period, to simulate the exposure as it occurred at work.

Some of the factors that lead to skin sensitization at work, and which cannot be duplicated in patch testing, are repeated exposures over periods of

weeks and months and the associated influence of sweating, occupational trauma, and other environmental incidents. The epidermal hypersensitivity which has resulted in a contact dermatitis may be confined to the area of dermatitis and a patch test cannot be applied to that site until long after recovery. Under such conditions a negative test may be misinterpreted. If the material used in a test is in stronger concentration than in the occupational exposure, or if it is in contact with the skin over a more prolonged period of time, or if the patient has a polyvalent sensitivity (cross sensitization), a false interpretation may be placed on a positive reaction.

It is sometimes advisable to make patch tests with materials with which the worker comes in contact outside of working hours or that are not related to the work. For example, I have seen dermatitis in parachute workers which resulted from fingernail lacquer and hair lacquer and that had been erroneously attributed to rayon and nylon materials.

Patients with active or quiescent eczema due to atopy or allergy may exhibit a nonspecific polyvalent sensitivity. Such individuals may show positive reactions to materials in industry with which they have not come in contact or which have nothing to do with the development of their dermatitis.

Infectious Eczematoid Dermatitis

Minor skin injuries, often neglected by the workers or receiving only a single first-aid treatment, frequently become infected with pyogenic organisms. Particularly when there is contusion or maceration of the epidermis in such cases, a protracted, spreading, and treatment resistant eczematous dermatitis may develop. A similar inflammation may be observed in the vicinity of a draining sinus following an injury or an operation, particularly when infected secretions from the wound or prolonged wet dressings macerate the epidermis. This frequently observed and important dermatitis was first described and recognized as an entity by Dr. Martin Engman, Sr., who named it "dermatitis infectiosa eczematoides" and attributed it to the Staphylococcus. It is often occupational in origin.

Infectious eczematoid dermatitis usually begins with the appearance of localized red edematous macules and papules which, through increasing intensity of inflammation, develop rapidly into grouped vesicles and pustules. These in turn rupture to form oozing, raw, edematous, coin to palm sized patches. Peripheral extension occurs by undermining of the epidermis at the margin of patches with vesicles and pustules, and with the formation of large areas of weeping dermatitis, possibly associated with regional lymphadenopathy. Chronic cases may continue for months and exhibit dryness and scaling and thin, firmly adherent varnish-like crusts that may crack, with exudation of serum and pus. The disease is not as pruritic as dermatitis venenata. It is particularly likely to develop when serous discharge is dammed up beneath heavy crusts and especially beneath the mortar-like covering of calamine lotion.

In the treatment of infectious eczematoid dermatitis bactericidal and bacteriostatic agents are needed but caution must be exercised to avoid aggravations of dermatitis. We have found potassium permanganate soaks or compresses, boric acid solution compresses, followed by boric acid ointments, or soft pastes or bacitracin ointment effective. Mercurial and penicillin ointments are frequently not tolerated. Sulfonamide ointments should not be used, but sulfonamides given orally, and sometimes penicillin by injection, are often helpful. Removal from work and bed rest may be necessary. Typhoid vaccine shock therapy is sometimes useful.

The Eczemas

The most important and most difficult dermatoses to differentiate from dermatitis venenata are eczematoid dermatoses such as atopic dermatitis or disseminated neurodermatitis, nummular eczemas of endogenous origin, and non-specific chronic eczematization of multiple origins.

Atopic dermatitis or *disseminated neurodermatitis*, also referred to as allergic eczema, usually involves the dorsae of the hands, both sides of the wrists, and flexural areas of the elbows and forearms, sites most commonly involved in dermatitis resulting from occupational contacts. The face and neck are likewise affected in both conditions, particularly in the former. Differentiation is not always possible without an accurate history, which, unfortunately, cannot always be obtained in an industrial case.

Atopic dermatitis usually develops in infancy and early childhood and is often associated with asthma or hayfever or a family history of allergy. It frequently becomes latent only to reappear or exacerbate at an age when young men and women enter industrial employment. This may be in late summer or fall, after a final school year, when seasonal factors such as pollen exposures and cold weather commonly aggravate atopic dermatitis. In the latter the primary shock tissue is the vascular structure of the cutis and the epidermis becomes secondarily involved. However polyvalent sensitivities may, and usually do, develop through both endogenous and exogenous sources that may result in acute attacks of dermatitis or in an aggravation of the existing dermatitis after irritant occupational exposures. Such dermatitis may not subside following removal from contact with the irritant that precipitated the attack and it may then develop into a protracted chronic eczema.

Nummular eczema is a designation applied to acute, recurrent, and chronic dermatitis characterized by well defined coin-shaped and coin-sized patches of dermatitis. It is observed most commonly on the back of the hands, but frequently on the forearms and also elsewhere. It may be solely endogenous or the result of a combination of internal

and external factors. Disturbances of metabolic processes, focal infections, and degenerative changes in vital organs or disturbances in their function may be wholly or partly responsible. It is seen frequently in persons past middle life and frequently of impaired or mediocre physical stock. It may be confused with infectious eczematoid dermatitis and localized or circumscribed neurodermatitis. The latter is an eczema of neurogenic rather than allergic origin.

Those cases of nummular eczema that resemble infectious eczematoid dermatitis and in which infection is not an etiologic or secondary factor are probably instances of autogenous sensitization to the patient's own tissue proteins absorbed from sites of destroyed tissue cells.

Dermatitis of the nummular eczema type is not infrequently observed in industrial cases, and it may be solely the result of contact sensitization. Chrome salts, such as potassium bichromate, lime, and cement and a number of other sensitizers may produce this type of lesion.

I believe that this latter group of dermatoses, commonly called eczema, require expert dermatologic management and frequently also the assistance of the allergist. Uncertain etiology and rebelliousness to treatment make them unsatisfactory to handle from the liability or insurance viewpoint. Because of the vagueness of our compensation laws as they apply to dermatologic conditions these are the cases that most frequently result in legal controversy.

Fungous Infections

Differentiation of fungous infections and sensitizations from dermatitis venenata, particularly that resulting from occupational contacts, is always an important problem. A widespread and persistent belief that the fungous conditions are quite prevalent, particularly on the hands, is not borne out by careful investigation. Direct fungous infections of the hands are actually infrequent. Allergic manifestations on the hands, resulting from infections elsewhere, particularly on the feet, are common but do not in any way compare in incidence with dermatitis venenata.

A common belief that allergic sensitization to fungous infections predisposes to contact dermatitis to a great degree is likewise an erroneous impression. Such predispositions, when they occur, may be chiefly due to physical factors such as breaks in the skin from fissures and ruptured vesicles opening the way for chemical irritants.

Contrary to the high incidence of fungous infections reported by many investigators, Schwartz and Peck recorded 28 per cent positive findings of fungous infection on the feet in 2,000 workers examined. In this group they observed only 10 cases of trichophytosis of the feet of such intensity as to require medical care, *i.e.*, 0.5 per cent, and only 3 cases of trichophytosis on the hands, *i.e.*, 0.15 per cent.

In 1948 I reviewed 811 consecutive case records of patients who had been seen in our office because of possible occupational dermatoses. One hundred and fifteen of these, or 14 per cent, were recorded as having some manifestation of fungous infection. Many of these diagnoses were not corroborated by laboratory evidence, and cases of concomitant fungous infection on the feet with dermatitis on the hands were included. A careful analysis of 230 consecutive cases of occupational dermatitis disclosed only 3 cases each of trichophytosis, trichophytid, and moniliasis as the lead diagnosis (1.9 per cent), and 5 cases of occupational aggravation of "ids" or dermatitis venenata secondary to "ids." In a group of 186 consecutive cases recorded as trichophytosis 6 (3.2 per cent) were listed as possibly of industrial origin and 4 (2.1 per cent) as the result of household activities. In a group of 100 consecutive cases of moniliasis, there were 24 instances of primary involvement of the hands and, of these, 2 (0.8 per cent) were attributed to employment and 2 to housework.

On a basis of practical considerations a diagnosis for or against fungous infection may be made at times on clinical findings, history, and response to therapy, but in industrial cases available laboratory procedures should be included in an investigation, and a diagnosis of fungous infection for legal considerations should not be made without laboratory support such as a positive potassium hydroxide examination or a positive culture. A diagnosis of trichophytid should not be made in any case without clinical evidence of a primary focus of active or latent fungous infection and a correctly interpreted positive trichophyton test.

It is my belief that irritant contact exposures are not responsible for the development of trichophytids on the hands in cases of commonly observed fungous infection elsewhere, as on the feet, and that, if they are "ids," they are the result of allergic reactions independent of occupational exposures. More commonly such eruptions on the hands are instances of contact dermatitis, dysidrosis, and miscellaneous manifestations of eczematization unrelated to the foot or other condition.

Peck and Schwartz state that there is no indication that the presence of an allergy to fungi bears a relationship to the acquisition of contact dermatitis, and they consider such sensitization a monovalent allergy.

The coexistence of fungous infection of the feet with dermatitis on the hands should not be the basis of a diagnosis of dermatophytosis or dermatophytid of the hands. Such diagnosis must be substantiated by thorough investigation.

There are, however, certain occupations in which primary fungous infections are seen from time to time. In *industry* these include meat slaughtering and packing, tanning, fruit and vegetable canning, and work in mills, grain elevators, malt houses, docks, and warehouses. In the *trades* fungous infections are observed most commonly in bakers, but also in hotel and restaurant employees, laundresses, housewives, bartenders, and lumber and wood

workers. In *agriculture* and *horticulture* cattle hands, stock farmers, farm hands, truck gardeners, dairy workers, and poultry dealers and gardeners are susceptible to infection with a variety of fungous organisms though the incidence is not high. In the *professions* and *specialized vocations* a liability to occupationally acquired fungous infection exists among veterinarians, game keepers, nurses, laboratory employees, barbers, cosmeticians, and manicurists.

Treatment of Industrial Dermatitis

Prevention, Protection, Cleansing

First consideration in the treatment of an industrial dermatosis applies to its prevention. Individuals with a history of recurrent dermatitis or with evidence of past or present dermatitis, and those with skins susceptible to dermatitis should be excluded from certain occupations. Pre-employment patch tests should not be used to determine fitness for employment except in certain isolated instances. An individual will not show a reaction to a substance to which he has not been exposed previously and such testing may result in a sensitization.

In any industry with a dermatitis hazard cleanliness is of paramount importance and employees should be instructed in this regard as well as in routine methods of combating and minimizing certain exposure hazards. Particular attention should be directed to the importance of caring for minor injuries, removing irritants from the skin, using suitable cleansers for the skin, such as mild soaps, and changing and cleaning work clothes frequently.

Mechanization to reduce direct hand contact with irritant chemicals should be given first consideration by the employer. Where irritant contacts cannot be avoided gloves and aprons of materials impervious to the particular chemical likely to produce dermatitis should be worn. When gloves are impractical or a hazard because of moving machinery, protective ointments, creams, or lotions should be used and specially selected for each type of exposure. For example, a lanolin and castor oil preparation is an effective protective against industrial solvents and a boric acid cream against alkalies. Protective creams and ointments are too numerous to list or discuss at this time and information concerning them is readily available. They should meet five requirements.

1. They must be of such consistency that they remain on the skin satisfactorily so as to furnish adequate protection against irritant contacts while at work;
2. They must be easy to apply before work and readily removed after work;
3. They must not contain primary irritants nor likely sensitizing agents;
4. They must be cheap to prepare in bulk.

A good industrial cleanser for general use is a superfatted neutral soap containing a wetting agent or synthetic detergent. Workers should be instructed not to use the solvents with which they work for the removal of paint, grease, oil, or ordinary shop dirt.

It has long been known that industrial cleansers and soaps are a frequent cause of dermatitis, but Klauder and Gross have recently made a valuable contribution to an understanding of the manner of action of industrial cleansers in the production of dermatitis. They have also revealed a surprisingly high incidence of such cases. In an analysis of 1,600 cases recorded under the Pennsylvania law they attributed 13 per cent to wet work, with exposures only to soap and water, alkaline salt detergents, and water alone, and 11 per cent to cleansing agents applied to the skin. They listed non-aqueous solvents as the predominant irritants.

They made a study of 103 detergents and recorded 94 of them as alkaline. All but 9 had a pH varying from 7 to 12. The waterless or dry cleansers now quite popular were included in the study and found to have a high pH. The normal pH of the skin was recorded as 4.5 to 6.5. Klauder and Gross observed a definite increase of several points in the pH of the skin after prolonged exposures to both soaps and soapless detergents. Return to a normal pH varied directly with the length of the exposures.

Increased alkalinity of the skin was considered to predispose to the development of dermatitis. They advocate the use of a buffer solution after prolonged and intermittent exposure to alkaline substances as a measure to reduce the liability to dermatitis. In addition to this, maceration and softening of the horny layer is undoubtedly a factor in the development of dermatitis in so-called "wet industries." Apparently the value of the newer cleansing agents as a protection against dermatitis has been much over-rated.

The treatment of dermatitis venenata acquired in employment requires special emphasis on removal from further contacts with the causative agents on continuation of work, or resumption of work, and attention to contaminated clothing and working tools and equipment. An exception may be made in cases of mild dermatitis where continuation at work may result in immunization or "hardening" to which reference has been made. The physician will exercise better judgment, however, if he warns the patient and the employer of the hazard of intensification of dermatitis with continuation of exposure.

In the case of a skilled workman a change of employment is not easily accomplished and continuation at work with protective and precautionary measures may be justified. Such measures may include specific neutralizing agents. For example, in the photo engraving industry, where dermatitis from chromium salts is not uncommon, the routine application of a 5 per cent aqueous solution of sodium pentathionate has been found very effective in reducing the incidence of dermatitis and in permitting workers with dermatitis to continue in their employment. Similar procedures have been adopted in many trades and industries where causative

agents are well known and where contact is not always avoidable.

In the individual case the treatment of dermatitis venenata practically always requires topical applications, and the simplest and mildest remedies are usually the best. Specific treatment is indicated when the exact cause can be determined and a definite neutralizing or desensitizing agent is available. In most cases the treatment is non-specific and symptomatic. Hospitalization is seldom necessary, but instructions to the patient or to the individual carrying out the treatment must be meticulous.

The various lotions, emulsions, pastes, and ointments, and when and how to use them, need not be detailed at this time. A formulary for industrial use should include prescriptions for lead subacetate lotion, aluminum acetate lotion, calamine lotion, calamine emulsion, and zinc oxide and oil mixtures, zinc and starch paste and ointments for acute and subacute cases. Wet dressings with boric acid solution or Burrow's solution properly carried out are invaluable. Chief reliance for relief of itching and other subjective symptoms of local discomfort should be placed on the routine topical measures for reduction of inflammation and not on antihistaminics, though commonly used antipruritics, such as phenol, may be added cautiously in low percentages.

Lotions containing considerable amounts of powder, such as starch and calamine lotion, should never be applied to exuding or vesicular surfaces. Exudates and powder form tightly adherent crusts which prevent drainage and frequently, through absorption of retained tissue products, produce a systemic sensitization reaction with consequent aggravation and extension of dermatitis. Ointments may act similarly. In acute and subacute dermatitis without exudation ointments may be applied, particularly at night.

In any stage of dermatitis, but particularly when it is acute, we believe calcium medication to be a valuable adjunct to local treatment. It may be given orally or by intravenous or intramuscular injection. Colloid baths with starch, oatmeal (aveeno), or bran are very useful for cleansing and sedation in generalized acute and subacute dermatitis, particularly if there is exudation and crusting.

The antihistamines when given orally sometimes relieve severe itching, especially when there is widespread vasodilation and an urticate type of reaction. Barbiturates, by allaying nervous irritability and insomnia incidental to severe dermatitis, are frequently quite effective. Bromides and chloral serve a similar purpose. Aspirin sometimes acts as a sedative.

In subsiding dermatitis ichthymal or naftalan may be added in 1 to 2 per cent strength to stimulate reduction of residual inflammation. In chronic dermatitis with thickening of the skin, tar preparations are often effective. Secondary infections should be treated cautiously. Avoid over-treatment and too aggressive measures and treat the patient as an individual, not as a case.

208 East Wisconsin Avenue.

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CHICAGO MEDICAL SOCIETY TO HOLD CLINICAL CONFERENCE MARCH 3–6

March 3, 1953, will mark the opening day of the four day annual Clinical Conference of the Chicago Medical Society. This conference is designed to be of interest to both the specialist and the general practitioner. It will be held at the Palmer House in Chicago and will present a variety of subjects setting forth the latest information available to the medical profession.

Conducting the conference will be a faculty ranging from 35 to 40 outstanding speakers, each offering a presentation relating to his specialty. In addition another group will give daily teaching demonstrations which will include the presentation of patients. They will emphasize the actual technic to be employed in handling orthopedic, medical, and pediatric problems. In addition to holding these demonstrations each day, there will be a panel discussion at a round table luncheon presenting topics of timely interest.

This is an activity of the Chicago Medical Society for its membership to whom no fee is charged. Those who are not members of the Chicago Medical Society are asked to register for the four days at the fee of $5.00. For further details, write to the Chicago Medical Society, 30 North Michigan Avenue, Chicago 2, Illinois.

Detection of Early Uterine Cancer

As It Looks to Your State Board of Health

THE purpose of these brief remarks is to highlight a few aspects of uterine cancer and its control. Genital cancers comprise 25 per cent of female cancer. Of these, uterine cancers are the most important being the second most common cancer in women and causing about 17,000 deaths in the United States annually.

At the end of the past century the outlook for women with uterine cancer was most dismal, the chance of cure being limited to those few with small lesions that could be removed through the vagina. Since then diagnostic and therapeutic advances have produced a favorable outlook that in actuality has not been fully achieved. In cervical cancer, cure rates approximating 80, 50, 30, and 5 per cent are being obtained for stages I, II, III, and IV, and rates for carcinoma *in situ* are expected to approach 100 per cent. Nevertheless the over-all cure rate remains at about 30 to 35 per cent, the yearly 17,000 deaths representing in the main those 65 to 70 of each hundred cases who had no chance of cure when treatment began.

This unhappy state, or wide disparity between actual and possible cure rates, exists mainly because of the fact that uterine cancers when they manifest themselves and are brought to the physician for diagnosis and treatment are severely weighted with a preponderance of advanced lesions. In many major clinics of the country early cervical cancer, stage I (lesions limited to the cervix) comprises only about 10 per cent of the total. As indicated above the chance for recovery from uterine cancer is inversely related to the extent of the disease when treatment is initiated.

Numerous factors involving both patients and doctors contribute toward the late diagnosis and subsequent high case fatality rates for uterine cancer. In general, there are two major reasons why uterine cancer is not discovered in an earlier stage. First, too few women are seeking periodic pelvic examinations. Second, too few physicians are encouraging and giving regular pelvic examinations to their women patients, the primary objective of which is to rule out cancer. Physicians, as a group, are placing more and more emphasis on preventive medicine. However, as far as cancer of the uterus is concerned, the emphasis is still inadequate. The application of existing knowledge could save many lives. There are still far too many unnecessary cancer deaths.

Accumulating evidence indicates that most uterine cancers remain localized and small for considerable periods of time during which they are subject to detection and cure, provided that they are looked for. In recognition of this and the fact that the most important thing women can do to protect themselves against uterine and other pelvic cancer is to seek early and periodic pelvic examinations, the State Board of Health recently produced a pamphlet for lay women promoting such practice. The pamphlet "Uterine Cancer" was first introduced to physicians to acquaint them with its content and to enlist their support and leadership in the wider promotion of this health practice which is so necessary to the obtainment of a further substantial reduction in pelvic cancer deaths. It is now being distributed to Wisconsin women with the hope that it will influence their health habits and thereby aid the family doctor in uncovering early curable cancers.

In closing it is desired to bring to the attention of the reader a recent article and a professional film which present detailed information of considerable interest on pelvic examination. In the *American Journal of Obstetrics and Gynecology* for July 1952, under the title of "The Presumably Well Woman," Dr. A. C. Siddall presents his findings in 2,264 examinations made on 1,131 examinees over an eight year period.

The motion picture, "Uterine Cancer—the Problem of Early Diagnosis," was produced by the National Cancer Institute and the American Cancer Society. It is rich in simple clinical and laboratory information which will aid the general practitioner. Gross and microscopic pathology of benign and malignant disease are demonstrated. It is a 21 minute, sound, color film and may be borrowed without charge from the Film Library of the State Board of Health.—A. L. Van Duser, M.D., M.P.H., *Director, Division of Cancer Control.*

MARQUETTE MEDICAL ALUMNI, ATTENTION

The Marquette Medical Alumni Association will hold its annual Spring Clinics at the Medical School on Saturday, March 28. Make a note of this date now. Further details will be given in subsequent issues of the *Journal.*

Wisconsin Anesthesia Study Commission of the Wisconsin Society of Anesthesiologists

Editor—DOROTHY W. BETLACH, M. D., Madison, Wisconsin

Explosion Hazards in the Operating Room

Any individual within an operating room may cause an explosion of the anesthetic mixture. The incidence of such explosions is rare in comparison with surgical and anesthetic causes of death such as pneumonia, hemorrhage, shock, embolus, overdose of anesthetic drugs, and asphyxia from respiratory obstruction. The dramatic publicity accorded one single explosion,[1] however, and the occurrence of other fatalities from such accidents warrants every possible precaution to eliminate hazards and maintain maximum safety in operating rooms.

Satisfactory analyses of anesthetic explosions have been difficult. Individuals are hesitant to report accidents, especially when fatalities occur. Investigations through voluntary reports were started by the American Society of Anesthesiologists in 1938. According to authoritative data assembled by it, explosion of an inflammable anesthetic agent occurs no more frequently than once in 70,000 administrations, and the mortality rate is but one in 150,000 surgical cases.[2] Constant search by this society, by the manufacturers of surgical equipment, and by the United States Bureau of Mines is being continued in an attempt to eliminate all possible controllable factors of the explosion problem.

The real danger of an explosion of an anesthetic mixture becomes apparent when it is realized that the visitor who comes into the room to observe the operation or a worker at the end of the table opposite the head of the patient, even more than any member of the operating team, is quite capable of causing an explosion.

To reduce hazards of an accident to the minimum a number of effective and simple precautions can be applied. The Wisconsin Study Commission presents a brief summary of some causes of explosions and approved recommendations for their prevention. The three conditions which must exist for an explosion to occur are as follows:[3]

1. the presence of an inflammable gas vapor or other substance;
2. the presence of oxygen either as pure oxygen, air, or nitrous oxide;
3. a source of ignition.

A major number of the anesthetic agents in use today form inflammable mixtures with oxygen. These include ether, ethylene, cyclopropane, vinethene, and ethyl chloride. Trichlorethylene, in a mixture with pure oxygen at a temperature above 25.5 C., also may form an inflammable mixture. Nitrous oxide is not inflammable but by virtue of its oxygen content the gas will support combustion once it is started. To eliminate the use of any of these agents or oxygen, which is an absolute essential, would be detrimental to the patient's safety and would probably cause an increase in morbidity and mortality rates. Likewise, it is ridiculous to ban the use of any one agent on the premise that that particular gas or vapor is more explosive than others. In concentrations of anesthetic range, all these agents form explosive mixtures.

Where indicated by the best medical judgment, anesthesiologists usually avoid the use of explosive agents in operations requiring electrical equipment such as cautery. Inflammable anesthetics are used, however, when all considerations indicate that the explosion risk to the patient is far less than would be the likely physiologic disturbances if a nonexplosive anesthetic was employed.[2]

In a combined analysis of several case studies covering 299 explosions and fires, ignition of gases by cautery, electrostatic spark, and suction-pressure machines accounted for the greatest portion of the accidents. Explosions have also resulted from the accidental mixing of oxygen with combustible gases at high pressures and the use of lubricating oil on oxygen valves or regulators. Occasionally they have been initiated by sparks or arcs in defective electrical equipment and the careless use of flames.[4,5]

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Short circuit	2
Breaking circuit	4
Cigarettes	2
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In the control of explosions by direct contact with an open flame or hot body, ignorance of anesthetic combustion and indifference to hazards are chief factors. It is estimated that an inflammable gas escaping from a machine or respiratory system is explosive only within one to two feet from the gas leak.[3] Cautery and diathermy should not be used near the head, neck, chest or respiratory tract while an inflammable anesthetic agent is being administered. Lighted cigarettes, matches, or other kindling agents are absolutely inexcusable in the operating

room or other localities where explosive agents are present.

Sparks from electric power circuits such as suction machines, switches, extension cords, outlets, high frequency apparatus, lamps including endoscopes, and x-ray apparatus can be regulated by maintenance of the equipment in perfect condition. All switches and connections for appliances should be of an explosion proof type. Where receptacles and plugs are not of the explosion proof type, they should not be placed lower than 5 feet above the floor or in any location where combustible anesthetic gases can pass over them or envelop them. Apparatus in general use should, where possible, be shockproof and motors sealed. Electrical apparatus should not be connected or turned on during an operation in the presence of escaping combustible gases. If there is any doubt of existing circumstances, the anesthetist should be consulted.

Sparks from static electricity are probably the most common cause of fires or explosions of combustible anesthetic gases and vapors, and their control is the most difficult factor in the operating room. No electrostatic charge or spark between two bodies can be built up in any location unless there is present some insulating material. Any insulating material will act as a barrier to the flow of electricity and thereby serve as a generator of electrostatic discharge. Considerable voltage may be generated by simple routine procedures such as the placing of drapes on a patient or sliding forward on a cushioned stool. Careful, deliberate movements by the operating team can help prevent the buildup of high voltages. Wool blankets, including those used during transport of the patient to the operating room; wool, nylon or silk outergarments; and ordinary rubber, synthetic, or crepe-soled shoes or shoes with metal heel plates are absolutely contraindicated. Conductive shoes or leather ones with rubber heels must be worn. There is evidence that personnel wearing properly covered *undergarments* of silk or synthetic materials do not acquire substantial static charge potential.

Sponge rubber cushions on stools; plastic drapes, mattress, and pillow covers; and platforms with rubber feet also are dangerous. Stools with smooth, rounded feet and bare-metal tops are the most satisfactory ones from the standpoint of electrical conductivity. Wide cross straps of adhesive tape, sometimes used to prevent sliding, are not objectionable, but at least 50 per cent of the bare top surface of the stool seat should be left exposed.[6]

The movement of individuals who enter the operating room may be extremely important. Street clothing, wool particularly, should be changed and shoes grounded. Visitors should not be allowed to make contact or come close enough for a spark gap with any object of the operating set-up. Nothing should be placed inadvertently on the anesthetic apparatus nor should it be touched without the anesthetist's approval. If one must be near the anesthetist, contact should first be made with him to establish isopotential state.

Anesthetists can do much to prevent static charges. Contact with the patient and the anesthetic apparatus should be made before induction and constant contact with the patient maintained during the anesthetic administration. In the assembly and adjustment of any part of the apparatus and its connection with the patient, the anesthetist should hold both parts in his own hands before making or breaking contact. Movements should be deliberate.

No single measure is sufficient to prevent all static sparking and other causes of explosion. Constant vigilance, thorough education, and awareness of the hazards are necessary in order to reduce or eliminate the occurrence of this complication which all too frequently is fatal. Compliance of every individual in the operating room is imperative.

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ANNOUNCEMENT OF VAN METER PRIZE AWARD

The American Goiter Association again offers the Van Meter Prize Award of Three Hundred Dollars and two honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland. The Award will be made at the annual meeting of the Association, which will be held in Chicago, May 7, 8, and 9, 1953, providing essays of sufficient merit are presented in competition.

The competing essays may cover either clinical or research investigations; should not exceed 3,000 words in length; must be presented in English; and a typewritten double spaced copy in duplicate sent to the Corresponding Secretary, Dr. George C. Shivers, 100 East Saint Vrain Street, Colorado Springs, Colorado, not later than February 15, 1953. The committee who will review the manuscripts is composed of men well qualified to judge the merits of the competing essays.

Clinicopathologic Conference

Editors—W. A. D. ANDERSON, M. A., M. D., Marquette University School of Medicine, Milwaukee and D. M. ANGEVINE, M. D., University of Wisconsin Medical School, Madison

PRESENTATION OF CASE*

A white male, age 67, was admitted to St. Mary's Hospital on April 7, 1952 and died five days after admission. His chief complaint on admission was vomiting and coughing up of blood. About two months previously a cold had developed and since then he had been coughing. Six days before admission he vomited blood, and on the day of admission he coughed and then vomited about a half glass of blood which was bright red. He had pain in the anterior aspect of the chest which radiated to the back. He had experienced severe dyspnea on slight exertion for some time. He had had precordial pain for the previous week which he had never experienced before. His right foot and ankle had been swollen. For the past six years he had been a laborer, but his occupation prior to that time was not known. His past history was not remarkable except for some dyspnea on exertion.

Physical examination revealed an obese white male in acute distress. Coarse rales could be heard on entering the patient's room. Chest expansion was equal; respirations were labored. No dullness was evident on percussion. Coarse moist rales were heard throughout both lung fields anteriorly. The heart rate was 128 per minute, and the blood pressure was 200/90. No heart murmurs were heard, but the heart tones were very distant. The right leg had a grade 2 pitting edema in the lower third.

Laboratory Examination: Hemoglobin content was 76 per cent; red blood cell count 3,910,000; white blood cell count 9,900 with 9 per cent stabs and 68 per cent segmented. A urinalysis was as follows: albumin, 1 plus; hyaline casts, few; and 4 to 5 red blood cells per high power field. Sedimentation rate was 107 mm. Sputum examination revealed bright red bloody mucus from which pneumococci and streptococci were isolated. Roentgen examination of the chest revealed increased density throughout the right lung and lower half of the left lung. Hilar shadows were greatly increased on both sides. The heart and aorta were moderately enlarged. An electrocardiogram revealed a right axis deviation and occasional ventricular ectopic beats. Rectal temperature on admission was 100.4 F.

During the patient's hospitalization his rectal temperature fluctuated between 99.4 to 100.6 F. He perspired freely and was constantly dyspneic. On the second day the patient complained of pain in the chest and "something sticking in throat." He vomited a green liquid and expectorated a bloody sputum. The following day the sputum was colorless. Distention and pain in the abdomen developed. He had two bowel movements of soft brown stool. On the fourth day he again expectorated bloody mucus. Abdominal distention increased. Bowel sounds were not heard. On the morning of the fifth day a large amount of bright red blood suddenly gushed from his nose and mouth and he expired within 15 minutes.

He was treated with oxygen, aminophylline, chloromycetin, digitalis, and sedatives.

Dr. B. G. Narodick: This 67 year old man was admitted to the hospital with a minimum past history and relatively few symptoms. His story is one of pulmonary or upper digestive tract hemorrhage which continued during his hospital stay, ultimately ending in massive bleeding that caused his death.

The past history is scanty. Cough and dyspnea were the predominant findings. Cough is generally produced by irritation of the bronchus, either by direct contact with the mucosa as with secretions, by intrinsic bronchial lesions, or by pressure from an extrinsic source. The same applies to irritation of the larynx and trachea. It would be of some value to know the nature of the cough. Was the cough accompanied by expectoration? Was it a brassy cough? If hoarseness was also noted, we would be suspicious of a lesion involving the recurrent laryngeal nerve together with one producing pressure on the trachea.

I gather that dyspnea for a "long time" means that it had been present for years. This would rule out such acute disorders as pneumonia or atelectasis. We should, therefore, consider the chronic causes of dyspnea such as asthma, emphysema, mediastinal tumor, aneurysm, bronchiectasis, tuberculosis, pulmonary neoplasm, and pulmonary fibrosis. Cardiac disease, acute pulmonary edema, and anemia can be ruled out by considering the course of the patient in the hospital.

Hemoptysis and hematemesis were the principal findings on admission. The first prerequisite to a rational diagnosis is to determine the origin of the bleeding. Patients may find it extremely difficult to differentiate between blood arising from the tracheobronchial tree and blood that is regurgitated. Frequently the patient may have hemoptysis, swallow the blood, and then when the stomach fills, blood is vomited. As a rule, blood coughed out is generally frothy and bright red, whereas vomited blood is darker or even coffee-ground in appearance. Hematemesis due to bleeding from esophageal varices is

*From St. Mary's Hospital, Milwaukee; **Dr. B. G. Narodick**, chest surgeon; **Dr. S. B. Pessin**, pathologist.

generally bright red unless changed in color by stomach contents. Where one feels that hemoptysis has definitely occurred, then he should suspect that hematemesis is not of esophageal or gastric origin. However, there are certain lesions that can cause bleeding from both the tracheobronchial tree and esophagus. I have seen 3 cases of esophageal carcinoma that ulcerated into the trachea or left main bronchus. Generally, when carcinoma of the esophagus is that extensive, the patient will complain of dysphagia. A lesion located in the mediastinum that ulcerates into the trachea and esophagus involving blood vessels may produce marked hemorrhages. I believe this patient bled from the tracheobronchial tree, although we have very little clinical information to substantiate such diagnosis.

Almost 40 per cent of patients presenting themselves to chest specialists complain of hemoptysis. The most common causes of hemoptysis are tuberculosis, bronchiectasis, bronchogenic carcinoma, and various circulatory disturbances such as cardiac failure with pulmonary congestion or pulmonary infarction. Infrequently hemoptysis may occur in pulmonary, bacterial, and mycotic infections, silicosis, and pulmonary fibrosis.

I have bronchoscoped several patients who complained of hemoptysis in which x-ray examination revealed calcification in the tracheobronchial region. The bleeding in those patients was due to erosion of calcified nodes into the bronchus. This is probably unlikely in this patient because we have no evidence to substantiate such a lesion.

The patient had complained of precordial pain since the onset of bleeding. This may have been due to myocardial anoxia. Surgeons know that loss of blood frequently produces postoperative precordial distress. The anterior chest pain of this patient will be discussed in the differential diagnosis.

The swelling of the right foot raises the question of phlebothrombosis or thrombophlebitis initiating pulmonary embolism with massive infarction. Massive pulmonary hemorrhage due to infarction is rather unlikely, and I have never seen such a case. If the infarction was massive, pain and shock would be expected. I cannot explain the ankle swelling. I do not believe it had anything to do with the patient's predominent lesion. The patient had a high systolic pressure with a pulse pressure of 110. I shall remark about the high pulse pressure later. The right axis may have been due to obesity or chronic pulmonary disease. I do not believe the kidney findings are of sufficient importance in the differential diagnosis. The patient's dyspnea had increased, and he had had repeated hemoptysis. Later distention and pain developed in the abdomen, and the patient vomited green fluid. I doubt whether the patient had mesenteric thrombosis.

I have neglected discussing the portable x-ray findings. There was evidence of infiltration bilaterally and, with a history of frequent hemoptysis, the infiltration may have been due to blood entering various bronchopulmonary segments. In a portable x-ray the mediastinal structures are distorted, and although in this x-ray there was some widening, a definite diagnosis was impossible. Portable x-rays are often misleading.

Because of the long history of dyspnea and cough we must suspect chronic pulmonary disease. Of the conditions that I mentioned previously we can dismiss asthma and emphysema which rarely terminate in this manner. Tuberculosis produces hemorrhage by ulceration of a pulmonary vessel, usually in a necrotic area. Ulceration of the tracheobronchial tree likewise produces bleeding but rarely in massive amounts. It would be unusual in a patient of this age to never have had evidence of tuberculosis previously. Bronchiectasis can be ruled out because there was no history of expectoration, frequent pneumonias, or other symptoms of the disease. Severe bronchiectasis is usually a disease of young people who commonly die before they reach the age of 40. Carcinoma of the lung can mimic almost any pulmonary disease and is a real threat to my tentative diagnosis. Mediastinal tumor belongs in this category. The remaining conditions such as pulmonary fibrosis and other chronic lung diseases rarely produce massive hemoptysis. Right axis deviation as shown in the electrocardiogram is a frequent finding in such cases.

My tentative diagnosis of the case presented is aortic aneurysm. Although it is found more commonly between the ages of 25 to 40 and is due to luetic aortitis, it can occur in later years as a degenerative disease. Aortic aneurysm can produce cough and dyspnea by pressing against the tracheobronchial tree. It frequently produces anterior chest pain that may radiate to the back. Because of the nature of the disease, aortic regurgitation may produce a high pulse pressure. Aortic aneurysm may erode the trachea or esophagus, and frequently before it ruptures, there is a leakage of blood. The pneumonia may have been the result of leakage of blood, and the terminal hemoptysis the final result of perforation into the trachea or bronchus. Unfortunately the x-ray does not substantiate this diagnosis.

Dr. Millard Tufts: What about bleeding from an esophageal carcinoma or diverticulum?

Doctor Narodick: Only a ruptured esophageal varix could cause such massive hemorrhage so that a patient would vomit bright red blood.

Dr. J. R. Dundon: How would you explain the edema of the lower third of only one extremity?

Doctor Narodick: I have discussed the possibility of thrombophlebitis and phlebothrombosis. It may be that the patient had an ankle sprain or other disorder which might have been diagnosed with a more accurate history or more adequate physical finding.

Dr. C. D. Jurss: Do you consider a sedimentation rate of 107 important?

Doctor Narodick: I believe the increased sedimentation rate is of no value in the differential diagnosis in this case. I seldom order sedimentation rate determinations for differential diagnostic purposes since it is increased in acute and chronic conditions, in carcinoma, and tuberculosis.

Doctor Jurss: I do not feel that it is right for one to leave the young men in this group with the impression that determination of sedimentation rate should not be done. We often depend on and follow patients closely with frequent sedimentation rate determinations.

Doctor F. B. McMahon: I think sedimentation rates are of great value in tuberculous patients and in the treatment of neoplastic diseases. It may be the only positive finding indicating metastasis or recurrence of carcinoma after surgery.

Dr. S. B. Pessin: In a given case when all clinical data are of questionable diagnostic value and the only positive laboratory finding is a persistent increased sedimentation rate, it is of importance only in the sense that it should stimulate further investigation.

Doctor Narodick: I did not intend to convey the impression that the sedimentation rate is not an important test. In rheumatic fever, arthritis, and other chronic conditions, the sedimentation rate is an excellent procedure in following the patient's course. I believe the test does not have significant value in the differential diagnosis of acute lesions.

Dr. M. C. F. Lindert: I doubt whether the patient had hematemesis because according to the history he had a soft brown stool. In massive hematemesis the stool would be black. There is too much concern about the blood pressure of 200/90. It is not uncommon in benign hypertension to have a high pulse pressure without the presence of an aneurysm. I have seen cases of carcinoma of the esophagus infiltrating and perforating the trachea without producing signs of esophageal obstruction. Carcinoma of the esophagus may also ulcerate large vessels. It seems to me that carcinoma of the esophagus or bronchus is the most likely diagnosis.

Doctor Narodick: I realize that carcinoma is a real threat to my diagnosis, and I have not discussed it more fully because it can mimic almost any disease.

Doctor Pessin: Postmortem examination revealed that this healthy-appearing man, weighing about 240 pounds, died from exsanguination due to perforation of the arch of the aorta into the left main bronchus. (Fig. 1) The perforation was due to extension of tuberculosis from the huge silicotuberculous tracheobronchial lymph nodes into the trachea causing ulceration of the trachea. The aorta was involved in the ulcerative process by traction of adhesions and ultimate extension of the tuberculous ulcerative process into the aorta. There was moderate silicotuberculous pneumoconiosis with extensive silicotuberculosis of the mediastinal, tracheobronchial, periaortic and perigastric lymph nodes. The lymph nodes ranged in size from 0.5 to 3 cm. in diameter. They were greyish-black, very firm, and some had areas of caseation necrosis. Caseation necrosis was more pronounced in the tracheobronchial lymph nodes.

Fig. 1.—Rupture of aorta into left main bronchus (posterior aspect). Note large tuberculosilicotic tracheobronchial lymph nodes.

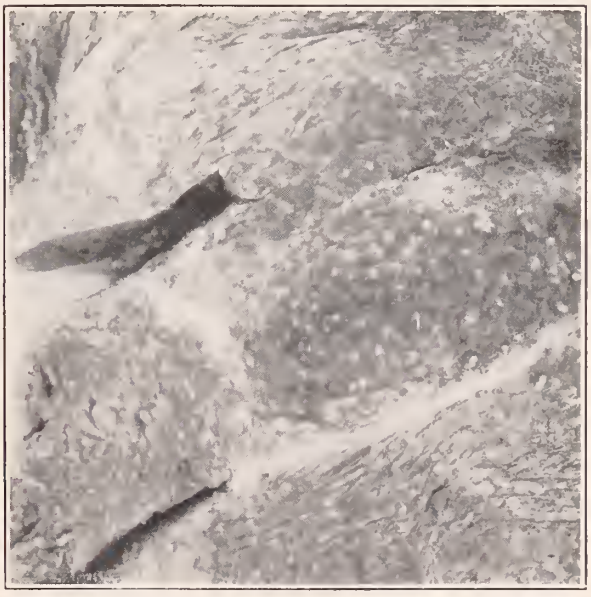

Fig. 2.—Pleural surface of lung showing a large scar with multiple silicotic nodules.

The left lung weighed 1,080 Gm. and the right 1,260 Gm. The pleural surfaces were bluish-black

and revealed very many small subpleural firm greyish nodules. (Fig. 2) The nodules in the lungs ranged in size from a pinhead to 3 by 2 by 1.6 cm. The largest nodules were greyish-black to black and of leathery consistency. There was moderate hypertrophy of the right ventricle, splenohepatomegaly, and multiple infarcts of the spleen and right kidney due to thrombotic emboli arising from the clot formed at the tracheo-aortic fistula. Also a thrombotic embolus straddled the bifurcation of the left iliac artery which, in my opinion, was an embolus from the region of the rupture of aorta into the bronchus, which broke off a large clot that had accumulated on the aortic side of the fistula. There were two traction diverticuli of the esophagus below the bifurcation of the trachea which were produced by fibrosed tuberculous tracheobronchial lymph nodes.

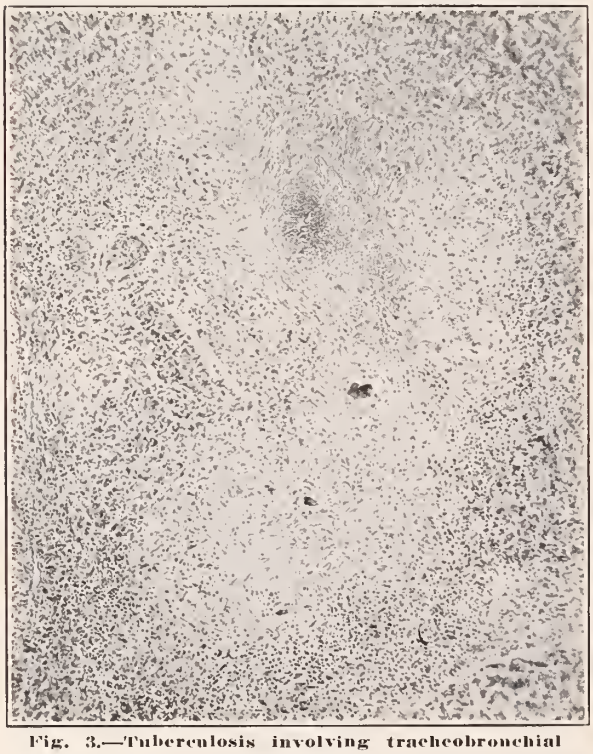

Fig. 3.—Tuberculosis involving tracheobronchial lymph node.

Microscopic sections of lymph nodes revealed marked fibrosis with isolated fibrosed tubercles. In addition some of the tracheobronchial lymph nodes contained large areas of necrosis and active tuberculosis. (Fig. 3) Sections taken from the trachea and tracheo-aortic fistula revealed tuberculous ulceration. Section of lung showed characteristic changes of silicosis, anthracosis and fibrosed tubercles. No definite active tubercles were encountered in the lungs. The hyalinized anthracosilicotic nodules were laminated. (Fig. 4) Many alveolar walls were thick. Thickened hyalinized vessels surrounded by fibrous tissue and anthracotic pigment were quite numerous (Fig. 5)

Doctor Narodick: This is indeed unusual. There is nothing in the history to suggest silicotuberculosis. What was his occupation?

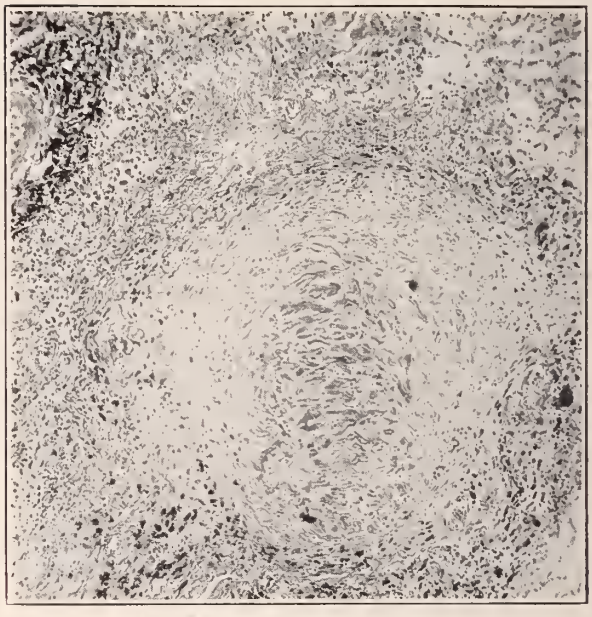

Fig. 4.—Lung: Silicotic nodule.

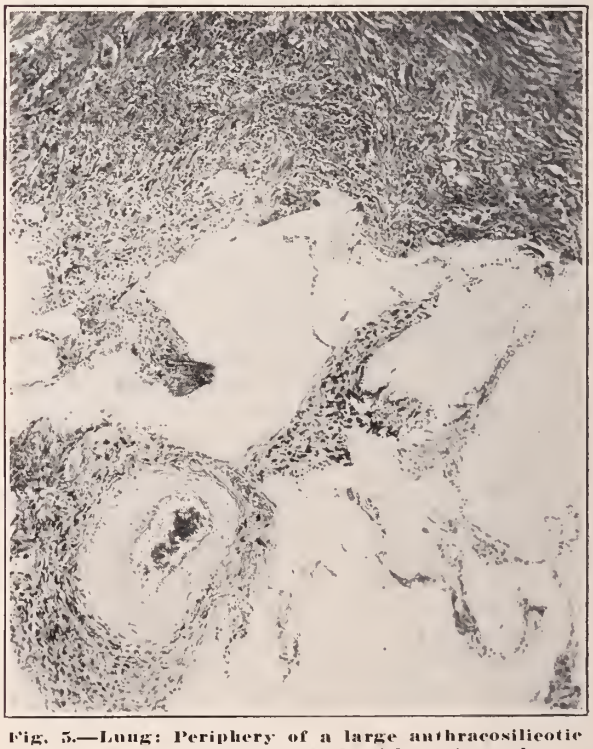

Fig. 5.—Lung: Periphery of a large anthracosilicotic mass. Note thickened vessel with perivascular fibrosis.

Doctor Pessin: I asked the attending physician, Dr. P. E. Oberbreckling, to inquire about the patient's past occupations. All he could learn from the people with whom the patient lived was that except for a slight cough the patient was healthy and active. For the past six years he worked as a laborer for the city of Milwaukee. Many years ago he worked in a steel industry.

Income Tax Provisions Affecting the Medical Profession

I. FEDERAL

Introductory

THE subject of federal income taxes continues to be increasingly complicated and technical. It cannot be simplified beyond a certain point. A physician will find it economical, from the standpoint of time and money to turn income tax matters over to his attorney and accountant, so that he may concentrate in his own professional field.

No effort has been made in this article to consider the special problems which arise in medical partnerships of two or more physicians, or in connection with the operation of larger units of medical practitioners, including clinics. In the first place, units of that size ordinarily employ an attorney and a consulting accountant. Second, although their problems in the main follow those of individual physicians, and the text which follows is generally applicable to them, certain of their problems, such as the fixing of shares of net income, donations and capital gains, are dependent upon individual agreements, and cannot be treated in a general article of this nature.

The advantages of preparing income tax returns correctly and of taking full advantage of all permissible deductions and exemptions are at least twofold. One is the saving of the physician's time. It is costly for him to have to submit needlessly to interrogation, by interview, letter, or audit. Second is the reduction in taxes, and the avoidance of needless later penalties and interest.

Those who desire more detailed information than is possible in a short general article of this type will find the following helpful: "Physicians Federal Income Tax Guide," by Campbell and Liberman, 1953 edition, published by Doniger & Raughley, Inc., Great Neck, New York, price $2.50. Also helpful, as soon as the 1953 edition is available, is "Your Federal Income Tax," which may be ordered from the Superintendent of Documents, Government Printing Office, Washington 25, D. C., price 25 cents. The informational pamphlet which can be obtained from your post office or from the Collector of Internal Revenue at Milwaukee or Madison about the middle of December should also prove helpful, although it is less detailed than either of the other two.

Recently available is "The Doctor's Tax Letter," published monthly by the Doctor's Tax Letter, Inc., 2000 No. Lincoln Park West, Chicago 14, Illinois. Each letter deals with a different phase of taxes affecting doctors. The yearly cost is $10.

New Rulings and 1952 Changes

1. Increase in Rates. The 1951 Revenue Act increased the surtax rates for individual taxpayers. While this increase was partly reflected in taxes paid for the calendar year 1951, the full impact of the rate increase comes in the calendar year 1952. For the calendar year 1952 the combined normal tax and surtax bracket rates range from 22.2 per cent on the first $2,000 of taxable net income to 92 per cent on taxable income over $200,000.

2. Capital Gains. The 1951 Revenue Act also made effective January 1952 the provision which changes the income tax treatment of certain capital gains. In substance, the change provides that a *short* term capital loss will offset a *long* term capital gain dollar for dollar, and a *short* term capital gain will offset a *long* term capital loss dollar for dollar. This is subject to a $1,000 annual limitation as to losses, after combining long and short term gains or losses. Through 1951, these offsets were in the ratio of $1.00 of short term to $2.00 of long term gains or losses, with a $1,000 annual limitation as to losses after combining long and short term gains or losses.

3. Head of Household. Likewise effective in 1952, the "head of a household" is permitted a limited privilege of splitting income somewhat in the manner of a husband or wife. He will not enjoy the same tax benefits permitted a husband, but will have a substantial saving from the tax otherwise due from him as a single person. For fuller treatment, see p. 1208, first column.

4. The Lilly Decision. On March 10, 1952, the United States Supreme Court handed down its decision in the case *Lilly v. Commissioner of Internal Revenue*. The decision seems to strengthen the professional man's position insofar as the deduction of "business expense" is concerned. The case involved the deduction by an optician of the commission of one-third of the retail price of glasses paid to the physician who referred the patient to the optician. The Supreme Court held, on the basis of evidence showing that such practice was common in the particular geographical area, that such commissions paid were ordinary and necessary expenses in carrying on the optician's business. The supreme court said that even though such payments may not be approved as a matter of professional ethics, this fact does not affect their deductibility for income tax purposes. The court pointed out, however, that in determining whether an expense is "ordinary" the ethics of the profession are evidence to be considered with and weighed against the other evidence dealing with the custom and practice in the profession.

As a practical matter, doctors should be entitled to deduct on the federal return all business expenses paid, provided the expense can be shown to be a usual one in the geographical area of practice. Of course, doctors will still need to show the necessary relationship between the expense deducted and the practice of his profession. Furthermore, any payment which violates a state statute, even though it is an expense connected with professional practice, can not be deducted.

Individual Federal Income Tax Calendar

1953

15th of each month (except January, April, July and October). Pay income taxes withheld on wages to a government depository if more than $100 in combined withholding and social security taxes (entire 3 per cent) was withheld during the previous calendar month. If $100 or less is withheld in a month, no payment for such month need be made until the quarterly return is filed on or before January 31, April 30, July 31, and October 31.

January 15. Pay final installment of estimated 1952 tax. Also final date for amending 1952 declaration of income, or filing a final return in lieu thereof. If a 1952 income tax return is filed by this date, it may incorporate any previous underestimate of 1952 income, and no penalty which would otherwise be imposed for underestimating such income will have to be paid if the full balance of the 1952 tax is forwarded with the return.

January 31. Due date of employer's return of income tax withheld and Social Security tax for last quarter of 1952; also for Form 940 by employers of 8 or more. Also deadline for withholding and Social Security tax payments. The employer must furnish to each employe whose wages exceed the amount of one withholding exemption during 1952, a written statement, Form W–2, showing the wages paid during 1952 and the amount of tax withheld on such wages.

February 28. Due date of information returns showing interest or rent payments of $600 or more, and wage payments of that amount not subject to withholding.

March 15. The following are due on or before this date:

(1) Due date of individual income tax return for 1952, for those whose tax year ends December 31, 1952, unless made on January 15. Any excess of tax shown on this return over tax withheld and amounts paid on 1952 tax is due on this date.

(2) Declaration of Estimated Tax for 1953; one quarter of estimated tax payable on this date.

(3) 1952 partnership and corporation income tax returns where the income tax year ends December 31, 1952.

(4) Gift tax return; and any gift tax due thereon.

April 30. Due date of employer's returns of income tax withheld and Social Security tax for first quarter of 1953. Also deadline for withholding and Social Security tax payments to accompany returns.

June 15. Due date of second installment of estimated 1953 tax; date for filing Declaration of Estimated Tax where requirements were first met between March 1 and June 2. Amendment of Estimate previously made may be filed at this time.

July 31. Due date of employer's return of income tax withheld and Social Security tax for second quarter of 1953. Also deadline for withholding and Social Security tax payments to accompany returns.

September 15. Due date of third installment of estimated 1953 tax; date for filing Declaration of Estimated Tax where requirements were not met until a date between June 1 and September 2. Amendment of Estimate previously made may be filed at this time.

October 31. Due date of employer's return of income tax withheld and Social Security tax for the third quarter of 1953. Also deadline for withholding and Social Security tax payments to accompany returns.

1954

January 15. Pay final installment of estimated 1953 tax. Final date for amending 1953 declaration of estimated tax, unless taxpayer prefers to file his 1953 income tax return by that date.

Withholding Taxes and Declaration of Estimated Tax

Employers Required to Withhold. Every physician employing persons for wages which are subject to the withholding tax must withhold from such wage payments an amount computed in accordance with the formula or tables provided by the Commissioner of Internal Revenue upon request. The amount so withheld must be paid by the fifteenth of the following month to a government depository (a designated bank) if a total of more than $100 in combined withholding and social security taxes (entire 3 per cent) was withheld from all employees during the previous calendar month. If $100 or less is withheld in a month, no payment for such month need be made until the quarterly return of taxes withheld is filed on or before January 31, April 30, July 31, and October 31.

Physicians should obtain from each employe an Exemption Certificate Form W–4 duly signed by the employe. This form should be obtained at the time employment begins. An amended form should be signed and filed with the employer whenever the employe's exemption status changes. If no certificate is furnished the employer, no exemption is allowed in computing the amount of tax to be withheld.

Wages Subject to Withholding—Exceptions. Wages subject to withholding include all remuneration paid to an employe, whether designated as salary, wages, fees, commissions, et cetera, and whether paid in cash or in something other than cash.

Excluded from "wages" and not subject to withholding are the following:

(1) Fees paid to public officials, such as notaries public and sheriffs.

(2) Compensation for services as a member of the military or naval forces of the United States in cases in which the pay is exempt because of combat zone service.

(3) Remuneration for agricultural labor.

(4) Payments for domestic service in a private home or college club or a local chapter of a college fraternity or sorority.

(5) Compensation for casual labor not in the course of employer's trade or business.

(6) Remuneration for services rendered as a minister.

(7) Professional fees of a self-employed physician or other person.

Statement of Taxes Withheld. The employer must annually furnish each employe in duplicate, with Form W–2, showing the amount of taxes withheld from his pay, even though no tax is deducted, if the wages paid to the employe exceed the amount of one withholding exemption as shown by the federal tables.

Filing Declaration of Estimated Taxes. Every physician must file a declaration of his estimated 1953 federal income taxes if:

(1) His gross income not subject to withholding tax is expected to exceed $100, and his gross income will be $600 or more.

(2) His gross income from wages subject to withholding can reasonably be expected to exceed $4,500 plus $600 for each exemption in addition to his own.

This estimate must be filed by March 15, 1953 and amended estimates may be filed on June 15, September 15, and January 15 following.

A husband and wife living together may file a single declaration on which they will be jointly liable.

Penalties. Penalties are provided for failure to file Declaration of Estimated Tax and failure to pay installments when required to do so.

For underestimating tax by more than 20 per cent (33⅓ per cent for farmers) the penalty is 6 per cent of entire shortage in estimate, but not more than the amount by which the estimate falls short of 80 per cent of the tax (or, in the case of farmers, 66⅔ per cent of the tax).

This penalty will not apply if (*a*) the estimated tax is computed on last year's income at this year's rates and exemptions, and is paid on time in equal quarterly installments, or (*b*) is paid ahead of time, or (*c*) an income tax return is filed and the full balance of the tax paid on or before January 15 of the succeeding year.

General

Joint Returns. Joint returns by husband and wife may again be filed for the calendar year 1952. Such split income feature is limited to spouses who live together and have the same tax year. Divorced or legally separated persons may not file such returns. Should one spouse die during the year who had the same tax year as the survivor, the survivor and the deceased spouse's estate may file a joint return and enjoy the advantages thereof as though both had lived. Husband and wife may file a joint return even though one of them has no gross income or deductions. It should be remembered that the signatures of *both* spouses are required on a joint return. *Each* spouse is jointly liable with the other, and also individually liable for part or all of the tax, as the government may elect.

When a Joint Return is Advisable. The filing of a joint return is optional just as it was in prior years. In almost all cases in which husband and wife have a combined net income over $2,000, after deductions and exemptions, it will be advantageous to file a joint return. One exception might be where both spouses have substantially the same income. A second exception might arise where 5 per cent of the combined incomes would be insufficient to cover the medical expenses of both spouses, although maximum advantage might be enjoyed on separate returns.

Where each spouse has taxable sales or exchanges of property, it may not be advantageous to file a joint return despite the income-splitting provisions. The only way to be sure whether a joint or separate return is more advantageous is to compute the tax both ways where the above exception appears.

Types of Returns. The federal government provides the following three types of personal income tax returns: Short-Form 1040, Form 1040A, and Long-Form 1040. In some cases no choice is open to the taxpayer in selecting a particular form over others. There are situations in which a choice is open, however, as appears from the text following.

The paragraphs following are taken from a pamphlet distributed by the United States Treasury in connection with the preparation of 1952 returns. Its language is simple and helpful.

"**Income Less than $5,000.** 1. *Form 1040A.*—This is the simplest return of the three. If you file this form, you do not need to figure your own tax. From your answers to the questions, the Director will figure your tax for you, and send you a bill or a refund. If your total income was less than $5,000 and consisted entirely of wages reported on Withholding Statements (Forms W–2), or of such wages and not more than $100 total of other wages, dividends, and interest, you may use Employee's Optional Income Tax Return (Form 1040A). If (1) you had any income from other sources, such as annuities, rents, royalties, a business or profession, farming, transactions in securities or other property, partnerships, estates, and trusts, or (2) if you claim the status of head of a household, you may not use Form 1040A but must file your return on Form 1040. You cannot deduct travel or reimbursed expenses from your wages if you file Form 1040A.

"2. *Short-Form 1040.*—Form 1040 may be used either as a short form or as a long form. The short form is simpler than the long form. It differs from Form 1040A in that (a) you must find your own tax; (b) you may include income from sources not eligible for Form 1040A; and (c) you may deduct travel and reimbursed expenses from your wages. Therefore, if your income was less than $5,000 and you do not desire to itemize nonbusiness deductions (contributions, interest, etc.), find your tax from

the table on the back of the form, tear off the first sheet and file it as a short form.

"3. *Long-Form 1040.*—If your nonbusiness deductions are more than 10 percent of your income, you will ordinarily save money by itemizing your deductions on Long-Form 1040. You will then figure your tax according to the computation on page 3, and file the entire form, which is called a long-form return. If your nonbusiness deductions are so close to 10 percent that you are in doubt which is the better form, try both the short form and the long form to make sure.

"**Income of $5,000 or More.**—If your income was $5,000 or more, you must use Long-Form 1040. However, in that case, you can either take a standard deduction or itemize and claim your actual deductions. You should compare your actual deductions with the amount the standard deduction allows you. If actual deductions exceed the standard deduction, you will save tax by electing to itemize them. If you are single, or if you are married and file a joint return, the standard deduction is 10 percent of your income but not more than $1,000. If husband and wife file separate returns, and each had income of $5,000 or more, the standard deduction is a flat $500 for each."

Your attention is also directed to page 1212, under the heading "Adjusted Gross Income Deductions" for a listing of those items which may be deducted even though the optional standard deduction is elected.

Personal Exemptions. Personal exemptions and credits for dependents are $600 per person. It should be noted that in the case of dependents the credit allowed the taxpayer is $600 but it may be taken for dependents whose income is less than $600. No credit for a dependent may be taken where the latter has filed a joint return with a spouse, no matter how much assistance is needed.

A special exemption of $600 for each taxpayer over 65 is permitted, *in addition to* the ordinary personal exemption of such person. The Act also allows an *additional* exemption of $600 if the taxpayer's *spouse* is over 65, or attains such age during the year, provided such spouse is not the dependent of another taxpayer. Any person attaining age 65 on or before January 1, 1953, may claim this additional exemption for the year 1952.

An additional $600 exemption for the blind is also allowed. It should be noted that where a person is over 65, or is blind, and is a dependent of a taxpayer *other than* a spouse, *no* additional exemption is allowed such taxpayer. As an example, a husband whose wife is over 65, blind, and dependent upon him for support, may claim a triple exemption of $1,800 for such wife. If a son were supporting the wife instead of the husband, and the facts were otherwise the same, the son could claim only $600 exemption for his mother.

Head of Household. Beginning in 1952, an unmarried person who is "head of a household" will be taxed at a lower rate than other unmarried persons, but at a somewhat higher rate than married couples who file a joint return. This may be accomplished by using a separate table of tax rates which apply only to heads of households.

A head of a household is any individual who is *not married* at the close of his taxable year, but maintains as his home a household which also constitutes the principal place of abode, as a member of such household, of:

1. His children, their descendants, or his stepchildren.
2. Any other person who is a dependent of the taxpayer.

In the case of the taxpayer's children, the descendants, or stepchildren, provided such persons be unmarried, it does not matter if such persons have income over $600 or more, or if the taxpayer did not contribute more than half of such persons' support. However, if any of such persons are married, they must first qualify as a dependent of the head of the household. For a discussion of who are dependents see the following heading entitled "Dependents."

The head of a household need *not* add the income of relatives living in the household to his own. Furthermore a head of a household, in addition to being able to use the lower rates, will still be entitled to take *all* of the exemptions for dependents that he otherwise would be entitled to. The head of the household must furnish not less than one-half of the cost of maintaining the household.

Dependents; Wife. The age of the dependent or his ability to support himself is not material. A dependent means one of the following persons over half of whose support for the calendar year in which the taxable year of the taxpayer begins was received from the taxpayer:

(a) A son or daughter of the taxpayer or a descendant of either.
(b) A stepson or stepdaughter of the taxpayer.
(c) A brother, sister, stepbrother or stepsister, half-brother or half-sister of the taxpayer.
(d) The father or mother of the taxpayer, or an ancestor of either.
(e) A stepfather or stepmother of the taxpayer.
(f) A son or daughter of a brother or sister of the taxpayer.
(g) A brother or sister of the father or mother of the taxpayer.
(h) A son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law of the taxpayer.

"Brother" and "sister" include a brother or sister by the half blood. A legally adopted child is considered a child by blood.

A taxpayer cannot claim exemption for a niece or nephew by marriage even though he has furnished more than one-half the support of such person or persons, unless his spouse joins in a joint return. To take an example, a husband who furnishes more than one-half the support of a niece

or nephew of his wife may claim an exemption for such niece or nephew only if his wife makes a joint return with him. The exemption will be allowed in such case even though the wife did not furnish the support and even though she did not have any taxable income.

The term "dependent" does not include any individual who is a citizen or a subject of a foreign country unless such individual is a resident of the United States, Canada, or Mexico.

A taxpayer is allowed a credit of $600 for a spouse who was not legally separated from him on the last day of the taxable year, although she is technically *not* a dependent.

No exemption for a dependent is allowed if the dependent's gross income was $600 or more, or if the dependent is married and has made a joint return with his or her spouse for the calendar year in which the taxable year of the taxpayer begins.

The fact that the dependent was not in existence throughout the year is immaterial. Thus, if a child of the taxpayer supported by the taxpayer is born or dies during the taxable year a full exemption is allowable for such child.

In like manner, a taxpayer who is married during the year and claims an exemption for his wife is entitled to a full exemption for her for that year, if at the close of his taxable year (ordinarily December 31) he was still married to such spouse, or, if she died during the tax year, he was married to her on the date of her death.

Alternative Tax. If there is an excess of combined net long term capital gains over combined net short term capital losses, the law provides an alternative method for computing the tax. Every dollar of such excess is taxed at a 50 per cent rate, and in some situations this may be lower than the tax regularly computed on Form 1040.

The use of the alternative method will never result in a tax liability lower than that regularly computed on Form 1040, unless *one-half* of the net income, less *one-half* the exemptions of husband and wife who make a joint return, exceeds $14,000. In the case of an unmarried person, or the separate return of a married person, the alternative method will never result in a lower tax liability, unless the net income, less exemptions, exceeds $14,000. In the case of a head of a household, the net income less exemptions must be $20,000.

These figures are only turning points, and the computations must be made by competent people, who will know whether the alternative tax increases or decreases the total tax liability.

For further consideration of this question see the subsection of this article beginning on page 1210. entitled "Capital Gains and Losses."

Compensation for Services of Children. Compensation for services rendered by a child shall be included in the gross income of the child and not in the gross income of the parent. The child is considered a separate taxpayer subject to the regular requirements as to filing and is entitled to a separate exemption for normal tax and surtax.

The parent or guardian of the child must file the required return where the child is unable to do so. Liability for the tax on compensation earned by the child is placed on the parent if not paid by the child.

Where the gross income of the child for the calendar year is $600 or more the parent is not allowed to consider the child a dependent.

Income

Items Reportable as Income. Broadly speaking, income includes all wealth which comes into the taxpayer's hands, other than as a return of capital. It is not even necessary in all cases that the income be *actually* received before the close of the taxpayer's reporting year for him to be obligated to report receipt of a certain item as income. Thus, salaries or bonuses are sometimes set up in a given year, and are made available to the taxpayer, although not paid to him until after the first of the following year. He would nonetheless have to report such items ordinarily because of the availability of such income to him. This is known technically as "constructive receipt" of income.

The same general rule would hold for dividend checks mailed before the close of the tax year, although not actually received by the taxpayer until a day or two after the first of the following year.

The following items, which have some application to physicians as a group, are reportable as income:

1. Compensation for professional services, whether in the form of salary, personal earnings from the practice of medicine, or the share of profits from a professional partnership between two or more physicians. The salary paid by a branch of government must also be included as income; as must a teaching salary, lecturing fees, and the like. Physicians sometimes have income for personal services of a non-professional character such as executor fees for handling an estate, or directors' fees received from a corporation as compensation. Such items are likewise reportable in gross income.

2. Earnings from investments. The most common of these would consist of cash dividends on corporate stock; interest from loans, bank savings, or bonds of business corporations; interest on U.S. savings bonds issued after March 1, 1941; rents from buildings and lands.

3. Income in the form of interest on life insurance proceeds held by the insurance company under an agreement to pay interest is includable in gross income. If a life insurance policy is surrendered by the insured for a lump sum in excess of total net premiums paid, the insured person realizes income to the extent of such excess over his cost.

As to annuities, or a matured endowment policy paid in installments under an option selected by the insured before the endowment matured, 3 per cent of the cost of such annuity or endowment is includable annually in gross income, if that amount or more is received in payments in a particular year.

The remainder of the income from either source for a particular year is excluded from gross income. When the aggregate amount excluded equals the cost of the annuity or endowment, the entire amount received thereafter must be included in gross income.

If any part of the survivor's interest in an annuity contract was included in the gross estate of a decedent for federal estate tax purposes, the survivor must include in gross income an amount equal to 3 per cent of the *estate tax* valuation instead of 3 per cent of the *actual cost* of the annuity contract, as was formerly the case. In the case of a physician who was a joint annuitant with his wife, this could be an important saving to whichever one of them survived the other.

4. In addition to items strictly classified as "income," one is also obligated to report ordinary gains and losses on the sale of property owned by the taxpayer in addition to capital gains and losses. The latter subject is separately discussed on this page. The subject of gains or losses, and when taxable or deductible as the case may be, is perhaps one of the most technical fields of federal tax law and should be placed in competent hands. Otherwise a tax may be paid needlessly in one instance, and penalties and interest needlessly incurred in another.

5. Income from royalties or from a farm or other business in which a physician is interested apart from his professional practice.

Items Not Reportable as Income. The following items are not required to be reported because exempt from taxation: gifts, bequests, devises and inheritances; damages received on account of personal injuries or sickness, whether paid by an insurance company or as a result of successful litigation; dividends on stock of federal reserve banks, land banks, intermediate credit banks and national farm loan associations if the obligations were issued prior to March 28, 1942; dividends from corporate earnings accumulated prior to March 1, 1913; amounts received through health, accident or workmen's compensation insurance, and damages received by the taxpayer for illness or injuries suffered by him; life insurance proceeds paid by reason of death of the insured (where a policy matures during life the amount of the proceeds, in excess of the net premiums paid, is taxable income).

Also, corporate stock dividends of the same kind as previously held by the taxpayer in the issuing company; payments to war veterans under the Adjusted Compensation Payment Act of 1936; earned income received from sources without the United States by a citizen who is a bona fide non-resident for certain stipulated periods of time except amounts paid by the United States or any agency thereof; pensions and compensation received by veterans from the United States, and pensions received from the United States by the family of a veteran for services rendered by the veteran to the United States in wartime.

Interest on obligations of a state or political subdivision thereof is excluded from taxation.

Partially tax-exempt interest on government obligations includes the following:

(1) Interest on the excess over $5,000 of United States Savings bonds (at cost) and Treasury bonds (at face value) issued before March 1, 1941.

(2) Interest on obligations of instrumentalities of the United States issued prior to March 1, 1941 (except Federal land banks, Federal intermediate credit banks, and joint-stock land banks).

(3) Dividends on share accounts in Federal savings and loan associations if the shares were issued prior to March 28, 1942.

The exclusion from reportable income of pay of United States servicemen for duty in combat zones applies until December 31, 1953. The exclusion also covers the pay of servicemen received for any month during any part of which the individual was hospitalized, as a result of wounds, disease or injuries incurred while serving in a combat zone after June 25, 1950, provided that during all of such month there were combatant activities in some combat zone.

Capital Gains and Losses. Capital gains and losses are now classified as follows:

(1) *Short-term* capital gains and losses are those resulting from the sale or exchange of capital assets held not more than six months.

(2) *Long-term* capital gains and losses are those resulting from the sale or exchange of capital assets held more than six months.

It is important to note that a net capital loss is deductible against ordinary income only to the extent of $1,000. The portion of the net capital loss which is disallowed, because it exceeds $1,000 in a given year, may be carried over to the five succeeding years to be applied against any future capital gains and also against other ordinary income up to the $1,000 maximum in each such future year.

The entire gain or loss from a sale of improved business real estate held *less than six months* is now treated as an ordinary gain or loss, with 100 per cent recognition for income tax purposes. If such property is held for more than six months, and if the gains exceed the losses from such property, the gains or losses are treated as though long term gains or losses. If the losses exceed the gains, both are treated as ordinary gain or loss.

If any securities issued by any corporation, including stocks, rights, bonds, debentures and other evidences of corporate indebtedness, are ascertained to be worthless and are charged off within the taxable year, the loss resulting therefrom shall be considered as a loss from the sale or exchange of capital assets *as of the close of the taxable year.*

Individuals not involved in the sale or exchange of any capital or other assets during 1952 need have no concern over these capital gains or losses provisions.

Capital gain treatment is denied on sales or exchanges of depreciable property between a husband

and wife, or between an individual and his controlled corporation. Any gain on sales or exchanges falling within the above situation will be taxed as ordinary income, at the maximum rate or rates applicable.

Installment Sales. Where a physician sells real estate, or where he makes a sale of personal property, such as his medical practice, or some other property which he is not in the business of selling regularly, and there is a profit on such sale, it is possible to spread that profit over a period of years, with consequent reduction in the income tax payable on such sale, assuming that he is otherwise in a favorable income position and so continues during the years when the balance of the payments are being made to him.

To gain such advantage it is required that the initial payment does not exceed 30 per cent of the selling price. The remainder, of course, can be payable in whatever manner the parties agree in subsequent years. As a general proposition where the profit on such a sale is substantial, it would probably be advisable to spread payments over three to five years, especially where the physician may not need the money at one time, and is secured on the balance.

In the case of personal property such as accounts receivable or a piece of machinery, it is also a requirement that the selling price must exceed $1,000.

There are two possible disadvantages which may diminish or eliminate the intended advantages of installment sales. One is that reduced income or deductible losses during one or more of the years of collection of an installment sale might be sufficient to offset part or all of the profit of the sale. A second possibility is that future Revenue Acts might eliminate the tax advantages now permitted in reporting long-term capital gains.

Nobody can foresee the future actions of Congress. It can only be said that to date those who have reported sales on an installment basis have in many cases derived a tax advantage from doing so. The matter should be carefully weighed by an attorney or an accountant.

Sale or Exchange of Residences—If a taxpayer sells property used as his principal residence and purchases a new residence within one year before or after the date of sale, a gain will be recognized only to the extent that the selling price of the old residence exceeds the cost of the new. The cost basis of the new residence must be reduced by the amount of nonrecognized gain.

Example 1: Mr. Brown sold his old home in March, 1952, for $16,000, which cost him $10,000 in 1942. In June, 1952, he purchased a new residence for $18,000. None of the $6,000 gain on his old residence need be reported. However, the cost basis of the new residence must be reduced by $6,000 (the amount of the nonrecognized gain on the old home), thus making its cost basis $12,000.

Example 2: Mr. Brown sold his old home in March, 1952, for $21,000, which cost him $15,000 in 1942. In June, 1952, he purchased a smaller home for $17,500. Of the gain of $6,000 on the sale of his old home, $3,500 is recognized, this being the amount that the sales price of the old home exceeds the cost of the new home. The $3,500 will be treated as a long term capital gain. The cost basis of the new home will be reduced by $2,500 (the nonrecognized part of the gain) to $15,000.

Where a new residence is constructed, construction of the new home must begin prior to the expiration of one year after the date of the sale of the old residence, and it must be used as the taxpayer's residence within 18 months after date of sale.

If either the old or new residence is used in part for business or rental purposes, the selling or cost prices must be allocated between residential and nonresidential uses.

The nonrecognition of gain rule applies only to one residence, the last so used, for each one year period.

Accounts Receivable Rule. Certain types of taxpayers, including physicians, are permitted by the federal act to report income on a *cash* as distinguished from an *accrual* or due basis. This is in recognition of the fact that much taxable income is not received by certain business and professional men until long after the tax period in which the right to receive such income accrued. This is notably true of accounts receivable, and also of notes receivable, rent and interest receivable.

Example: A physician charges his patients a total of $25,000 on his accounts receivable records in a given year, but collects only $15,000 of it in cash during that year. He also collects in cash during that same year the further sum of $5,000 in payment of services rendered by him to patients in prior tax years. His gross *cash* income for that year is thus $20,000, while his gross income on an *accrual* basis is $25,000.

Generally speaking, it is advantageous from a tax standpoint for a physician to report and pay only what is *actually received* in accounts, notes, interest, rent and similar items, because his losses from these sources are so much higher than those of a commercial concern. Physicians recognize this fact from experience, and almost universally report on the cash basis.

Upon a physician's death, the accounts and notes receivable outstanding at his death are not treated as income excepting as they are collected, where the deceased person reported his income on a cash basis. At the time of collection such income is taxed to the estate or to the beneficiary of the estate, depending upon the recipient.

It is important for the practicing physician to observe the following bookkeeping precautions which may have the effect of reducing his tax liability in a proper and legal manner:

1. Do not leave on your books, as receivables, accounts due from patients, notes due from patients, interest from loans or other obligations due you, or rental to which you are entitled from leased property, where such items are of doubtful collectibility or known to be uncollectible. Your estate may have trouble in proving an

account is bad and getting an allowance for it, thereby compelling payment of a tax on an account which neither you nor your heirs will ever collect.

2. Write off known bad accounts and notes at least annually, even though you are reporting on a cash basis. If you are reporting on an accrual basis, set up adequate reserves for bad and uncollectible accounts and charge against the reserve all accounts known to be in this classification.

3. Keep in your files such information as your patients and other debtors volunteer, or which you obtain from other sources, which will provide a basis for showing such accounts to be uncollectible, or at least very doubtful.

This rule is limited to the federal income tax, does not affect the state income tax due, and does not involve the valuation of your assets or the computation of taxes due from your estate either to the federal or state governments.

Deductions

Deductions which will be allowed on the federal tax return are discussed in detail under the heading "Explanation of Deductions," beginning on page 1213.

Allowable deductions are of two types: those which can be deducted as expenses in arriving at the net amounts of income set forth on pages 1 and 2 of the return, and those which can be deducted only on page 3 of the return. Hereafter in this article, the former are designated "Adjusted Gross Income Deductions" and the latter as "Page 3 Deductions."

Optional Standard Deductions. In lieu of page 3 deductions the "standard deduction" may be used. Some physicians may find this to their advantage. See page 1208 of this article, first column, under the heading "Income of $5,000 or More." Bear in mind, however, that Adjusted Gross Income Deductions may be claimed whether page 3 deductions are itemized or the optional standard deductions used.

Adjusted Gross Income Deductions. Of the deductions listed in a later paragraph, under the heading "Explanation of Deductions," those which fit into any of the five categories set forth below should be deducted from gross income to arrive at adjusted gross income, and only the net income should be shown under items 2, 3 and 4, page 1 of the return (Form 1040).

In cases where the deductions are from wages, salaries, bonuses, etc., received from an employer, a separate rider should be attached to the return showing (a) gross compensation; (b) the detailed deductions; and (c) the net amount which will be carried to line 2, page 1, of the return.

In cases where the deductions are from income *other than* compensation for employment, as where a physician practices alone, the detailed deductions should be set forth on page 2, schedules C or F.

Deductions which do not fit within any of the five categories set out below *must* be deducted on page 3 of the return.

The five categories of expenses deductible from gross income on pages 1 or 2 are:

(1) Deductions attributable to the trade, business or profession carried on by the taxpayer, if such trade or business does not consist of the performance of services by the taxpayer as an employee.

(2) Deductions which consist of expenses of travel, meals, and lodging while away from home, paid or incurred by the taxpayer in connection with the performance by him of services as an employee.

(3) Deductions (other than expenses of travel, meals, and lodging while away from home) which consist of expenses paid or incurred by the taxpayer, in connection with the performance by him of services as an employee, under a reimbursement or other expense allowance arrangement with his employer.

(4) Deductions attributable to property held for the production of rents or royalties.

(5) Deductions which consist of certain losses from the sale or exchange of property.

An employee, it should be noted, can deduct expenses in arriving at the net amounts of income set forth on pages 1 and 2 of the federal return, *only* if those expenses fit within the term "traveling expenses", or are reimbursed expenses. All other allowable deductions of employees *must* be set forth on page 3 of the return.

The significance of allowing the expenses to be deducted in arriving at the net amounts of income set forth on pages 1 and 2 of the return lies in the fact that these deductions may be claimed even though the Optional Standard Deduction be also claimed; whereas, deductions which must be set forth on page 3 of the return are deductible *only* if the Optional Standard Deduction is not claimed. The proper classification and separation of allowable deductions, as above suggested, will in some cases result in a reduced tax liability.

Deductible "Business Expenses" of Employees. Generally, in order for expenses incurred by an employee taxpayer in carrying on his occupation to be deductible from compensation, (a) the employee must be required, by the terms of his employment, to bear such expenses himself, (b) the expenses must be related to the employer's business, and (c) they must be reasonable in amount.

The basis for requiring an employee to bear the expense lies in the rule that one taxpayer cannot deduct expenses of another.

All allowable "business expenses" of employees must be deducted from adjusted gross income to arrive at net income (page 3 of the return), except as set forth on this page of this article, under the heading "Adjusted Gross Income Deductions."

Index to Deductions

Deductions which will be allowed on the tax return, some of which are peculiar to physicians, are listed below. The number given after each heading refers to the paragraph numbering on the pages following. The paragraphs explain in detail how to arrive at the deductions and depreciation.

With reference to depreciation allowable, the rate of depreciation not only depends on the prospective life of the property when acquired but also on the particular conditions under which the property is used as reflected in the taxpayer's operating policy.

The rates given below are therefore suggestive and tentative rather than final in character.

Automobiles, 1.
  Depreciation.
  Driver, 1.
  Insurance, 1, 11(b).
  Maintenance.
  Repairs.
Bad debts, 2.
Bandages, 4.
Depreciation.
  Automobiles—20 per cent annually on cost price, 1.
    Classification includes snowmobiles and other motive equipment.
  Instruments, 4.
    10 per cent annually on cost of surgical instruments and general equipment; 10 per cent on cost of x-ray equipment. Rate must be reasonable.
  Medical library, 3.
    10 per cent annually of cost price.
  Office building, 5.
  Office equipment, 5.
    10 per cent annually of cost price (average).
Dues, 7.
Equipment, 4.
  Both long and short-lived.
Fire losses, 11(d).
  Professional equipment and other property.
Income, what is, 1212.
Income, what is not, 1213.
Installment sales, 11(9).
Instruments, 4.
Insurance premiums.
  Automobile, 1.
  Hospital and surgical, 11(f).
  Malpractice, 11(b).
  Professional equipment, 11(b).
Interest paid 11(h).
Laboratory materials and expenses, 4, 11(c).
Legal expense, 11(a).
Library, 3.
Licenses, 8.
Medical expenses, (personal and family) 11(f).
Medical meetings, 9.
Medical Society group health and accident annual premium, deduct $17—See 11(f).
Medical supplies, 4.
Office expenses, 5.
  Heat, light, supplies, telephones, water, short-lived office equipment, annual depreciation on furnishings and fixtures.
Office rental, 6.
Post graduate studies, 9.
Professional dues, 7.
  American Medical Association.
  County Medical Society.
  State Medical Society.
  Special societies as:
    American College of Surgeons.
    American College of Radiology.
  Any other paid in interest of profession.
Salaries, 10.
Scientific meetings, 9.
Sales of spectacles, 11(e).
Taxes and licenses, 8.
  Alcohol license.
  Automobile license.
  Gasoline and oil taxes.
  Narcotic tax.
  Occupational tax.
  Property (real and personal)
  Professional equipment and material taxes.
  Reregistration fees.
  Social security taxes.
  State income tax.
  State unemployment compensation tax.
Theft of professional equipment, 11(d).
Traveling expenses, 9.
  Both professional calls and scientific meetings.
Wages and salaries, 1, 10, 11(c).
  Clerk, 10.
  Driver, 1.
  Laboratory assistant, 10, 11(c).
  Maid, 10.
  Nurse, 10.
  Physician, 10.
  Stenographer, 10.
  Any other employe rendering service in connection with taxpayer's practice or in the care and treatment of patients, 10.

Explanation of Deductions

1. **Automobiles.** The cost of operation and maintenance of an automobile used in making professional visits is deductible. These costs include gasoline, oil, tires, insurance, repairs, garage rental, driver's wages and depreciation. If the same car is used for both professional and personal purposes, only such part of the maintenance and depreciation as arises out of the use for professional purposes is deductible. Sums spent for taxi, bus, or railroad fare, *while on professional calls*, are deductible.

Depreciation is based upon the estimated useful life of the car. If that period be five years, 20 per cent depreciation based on cost price may be taken annually for five years. What has been said with respect to automobiles applies to other motive equipment.

The "cost price" for an automobile, or other business property, acquired on a trade-in of a similar asset is the depreciated cost of the old asset plus the boot money paid.

Example: Mr. Green bought a car in July 1950, for $500 cash, which was traded in July 1952, for a new one. It was used 50 per cent in business and depreciated at the rate of 20 per cent. Fifty per cent of two years' depreciation is $100. Its depreciated cost is therefore $400. One thousand dollars was paid to boot for the new car. The "cost price" of the new car is therefore $1,400.

2. Bad Debts. If the physician's books are kept according to the "Cash Receipts and Disbursements" system, he may not charge off any unpaid debts because "if his books are kept according to this system, he is only reporting as gross income those accounts which have proved to be good, and therefore bad accounts cannot be deducted because they have already been excluded."

If the books are kept upon an "accrual basis" (that is, on the basis of expenses actually incurred and payable even though not yet paid, and income earned although not yet collected), it is permissible to charge off all debts which have been definitely ascertained to be worthless, and have been charged off on the books or records during the fiscal year covered by the report.

3. Library. Most physicians maintain a professional library. Taken as a whole it is doubtful whether the useful life of such a library exceeds ten years. Accordingly, annual depreciation of 10 per cent of the cost of such library may be deducted.

4. Medical Supplies and Instruments. Medicines used in the physician's office to treat patients, bandages, laboratory materials, and all other medical supplies required for the operation of a physician's office may be deducted as necessary expenses, *as may equipment, the life of which is less than one year.*

The average useful life of surgical instruments and equipment generally is now estimated at ten years, which means that 10 per cent of the cost may be taken as reasonable annual depreciation. X-ray equipment may ordinarily be depreciated at 10 per cent of cost.

5. Office Expense. General office expense is deductible. Among the principal items are heat, light, office supplies, telephone, rentals, water, office equipment having a useful life of a year or less, and depreciation on office furnishings and fixtures. Ten per cent of original cost is a reasonable *average* depreciation rate for office equipment, furnishings and fixtures. Specific items may be higher or lower than this rate. Thus, a typewriter which, it was estimated, would last only five years would warrant a 20 per cent annual rate; while metal filing cabinets, with an estimated useful life of not less than twenty-five years, would justify only a 4 per cent annual rate.

Where the space used for the conduct of a professional practice, including waiting rooms, examination rooms and laboratory, is owned by the taxpayer physican, or by a partnership of physicians, a reasonable depreciation may be taken annually on such building, based on its cost and life expectancy. If only a portion of a building is used for professional purposes, depreciation may be taken only on such portion.

6. Office Rent. If a physician pays rent to another person for office space, he is permitted to deduct the amount from his gross income. This includes regular office space in a rented home provided office hours are maintained there. Where a physician maintains his offices in a rented home he may deduct as rental expenses only that proportion of the total rent paid which his office space bears to the entire house.

7. Professional Dues and Subscriptions. Dues paid to professional associations to which a physician belongs in the interest of his profession are deductible. Subscriptions to medical journals or scientific publications are likewise deductible as expenses.

8. Taxes and Licenses. Taxes paid upon materials required in professional work are deductible. All licenses which the physician is required to take out may be deducted. This includes the license to prescribe alcohol, narcotic license, automobile license, local occupational and reregistration taxes. State taxes on gasoline and motor oil, state income taxes paid, payments made under the Wisconsin unemployment compensation act and payments made by the physician as an employer under the Social Security Act are also deductible. The social security tax deducted from the income of a salaried physician is not deductible by him, however, since it is considered an income tax.

The physician may also deduct all real estate and personal property taxes paid by him, even though the property taxed is not used for professional purposes. This would include, for example, taxes on a vacant lot or on a launch.

Nonbusiness taxes paid during the tax year by one on a cash basis are generally deductible, except for: Federal income tax; federal estate and state inheritance taxes; federal or state gift taxes; federal excise taxes, such as those of theater tickets, jewelry, furs, silverware, transportation, cigarettes, telephone, and the like. Also non-deductible are: the employee's share of federal old age insurance tax; federal transfer taxes on corporate securities or real estate; state or local property assessments for improvements; and state and local taxes on tobacco and cigarettes which are not imposed on the consumer (including Wisconsin). Excise taxes on transportation and communications are deductible if paid in connection with business expenses. Transfer taxes on corporate securities and real estate are not deductible as such, but the amount thereof may be used to reduce the selling price, which has the effect of allowing them as expenses. However, such taxes relating to property used in business are deductible from adjusted gross income, as explained above, while nonbusiness deductible taxes must be listed on page 3 of the return.

9. Traveling Expenses. Traveling expenses necessary for professional visits to patients are deductible. Traveling expenses in bona fide attendance upon scientific meetings are deductible. The expenses of attending postgraduate medical courses are *not* deductible, however.

10. Wages and Salaries. Deductions are permitted for the salary of a physician, nurse, laboratory assistant, stenographer or clerical worker employed in the office so long as the duties of such persons are in connection with the physician's professional work. Wages paid to maids taking care of the office and answering the telephones are also deductible, as are any sums paid employees for services rendered in connection with the taxpayer's practice, or the care and treatment of patients.

11. Miscellaneous. (a) Legal Expenses.—Legal expenses incurred in connection with the taxpayer's profession or business, including the prosecution of tax assessments or refunds, are deductible, but legal fees paid for general personal legal services are not deductible. Expenses incurred in the defense of a suit for alleged malpractice are likewise deductible as business expense. Expenses incurred in the defense of a criminal action, however, are not deductible.

(b) Insurance Premiums—Premiums paid for insurance against professional losses are deductible. This includes insurance against damages for alleged malpractice, against liability for injuries by a physician's automobile while in use for professional purposes, and against loss from theft of professional equipment, and damage to or loss of professional equipment by fire or otherwise. Under professional equipment may be included any automobile belonging to the physician and used partially or wholly for professional purposes.

(c) Laboratory Expenses—The deductibility of the expenses of establishing and maintaining laboratories is determined by the same principles that determine the deductibility of other corresponding professional expenses. Laboratory rental and the expenses of laboratory equipment and supplies and of laboratory assistants are deductible when, under corresponding circumstances, they would be deductible if they were part of a physician's general office expense.

(d) Losses by Fire, Theft, etc.—Loss of and damage to a physician's equipment by fire, theft or other cause, *not compensated by insurance or otherwise recoverable*, may be computed as a business expense and is deductible, provided evidence of such loss or damage can be produced. Such loss or damage is deductible, however, only to the extent it has not been made good by repair and the cost of repair claimed as a deduction.

Deductions may likewise be taken for loss of or damage to *nonprofessional* property of a physician caused by fire, flood, theft, storm, or other casualty *where not compensated for by insurance or otherwise*. Examples of this type of casualty would include damage to trees and shrubs caused by storm or flood; damage to floors and furnishings caused by bursting water pipes; injury to boats or launches caused by storms; damage to a car, whether caused by the physician's negligence or that of someone else.

To repeat, such items as those above indicated *cannot* be deducted where, or to the extent that, the taxpayer is compensated for such loss by insurance settlements, law suits, or sums paid over without law suits by a person or persons causing the damage.

Special relief is also given to persons who have suffered heavy casualty losses; for example, an individual whose property has been destroyed by flood. In effect, the measure allows taxpayers who have a taxable loss, rather than a taxable income, occasioned by a casualty loss, to carry this loss back one year and forward five years so as to offset income in the preceding year or the five succeeding years.

(e) Sale of Spectacles—Oculists who furnish spectacles, etc., must enter as income money received from such sales and deduct as an expense the cost of the article sold. Entries on the physician's account books should, in such cases, show charges for services separate and apart from charges for spectacles.

(f) Medical Expenses. Medical, dental, drug, nursing, hospital, and related expenses, including fees for services rendered by other physicians, *which are in excess of* 5 per cent of the taxpayer's adjusted gross income, may be deducted if *actually paid* during a given year. The provision "which are in excess of 5 per cent of the taxpayer's adjusted gross income" does not apply, by virtue of the 1951 Revenue Act, to the situation where *either* the taxpayer *or* his spouse is over 65 years of age, although it does apply to their dependents. The cost of hospitalization and surgical insurance may, except as provided below, be included in such deduction, as may travel where directly related to hospitalization or recuperation, and the travel expenses of a minor child and parent, which are directly related to hospitalization and medical care. The taxpayer cannot claim a deduction for travel for general health, unrelated to a specific condition requiring change of climate, or for general health travel combined with vacation.

Premiums for policies which pay hospital, surgical, medical, and related benefits are likewise deductible, as is that portion of the total premium of a health and accident policy which represents such benefits. Such premiums are deductible whether the benefits are payable directly to the source of service, or as indemnity to the insured physician. Premiums for disability or time loss insurance, and for accidental death and dismemberment, are *not* deductible, however. Physicians enrolled in the Provident Life & Accident Insurance Company group disability and hospitalization plan, which has been carried through the State Medical Society since August 15, 1950,

may deduct the hospital benefits portion of the annual premium, which is $17.

To the extent that any health expenses are compensated for by insurance or otherwise, they are not to be included. For example, if the annual cost of a hospital and surgical benefit policy during 1951 was $72, and $60 in benefits was received from such policy during the year, only the difference between the cost and the benefits, or $12, could be shown as the net cost of this medical expense item for 1951. If more than $72 was received in benefits during the year, *none* of the premium cost is deductible as medical expense, since the taxpayer received in benefits more than he spent as premium. Where the cost of health insurance has been deducted in one tax year and its cash benefits are not received until a subsequent year, such benefits must be deducted from the premium costs in such latter year. If the benefits received in such latter year exceed the premium cost for that year, the excess of benefits over the total premium must be included in the gross income for such year.

The maximum deduction for medical expenses on a separate return for one exemption is $1,250, and for two or more exemptions is $2,500. The maximum deduction in the case of a joint return by husband and wife is $2,500 where there are no other exemptions, as for dependents. This amount is increased to $3,750 where there is a dependent in addition to husband and wife, and to $5,000 where there are two or more dependents in addition to a husband and wife who make a joint return. The maximum allowances are summarized in the following table:

Joint Return	Maximum Allowable
Husband and wife	$2,500
Husband and wife and one other exemption	3,750
Husband and wife and two or more other exemptions	5,000
Separate Return	
One exemption	$1,250
Two or more exemptions	2,500

Situations may arise where, by reason of the rule limiting medical expenses to the excess over 5 per cent of adjusted gross incomes of husband and wife, a joint return will decrease the medical deduction in some cases. This will seldom occur, however.

The expense must be for the medical care of the taxpayer, his spouse, or a dependent. Taxpayers are required to furnish the name and address of each person to whom such expenses were paid, and the amount and approximate date of payment. Where a joint return is filed, the 5 per cent limitation is computed on the aggregate adjusted gross income of husband and wife. Payments for waiver of premiums on a life insurance policy are *not* includable as medical expense.

Example: Assume the taxpayer has a gross income of $10,000 and that the total of the medical, dental, hospitalization and related expenses paid in a given year for himself and his family was $1,500. Since there is no recognition given to such expenses up to the point where they equal 5 per cent of his adjusted gross income, the first $500 of his expenses are not deductible. He would, therefore, be allowed to deduct only the remainder, or $1,000.

(g) **Interest Paid.** With the two exceptions noted in this paragraph, all interest paid by a physician is deductible for federal tax purposes, even though it may have been for a non-professional indebtedness, such as the purchase of a home. The two exceptions are: (1) Interest paid on an indebtedness incurred to purchase or continue ownership of securities, the interest on which is wholly tax exempt; and (2) Interest paid on an indebtedness permitting the purchase of a single-premium life insurance or endowment contract. An insurance purchase is considered on a "single-premium" basis if substantially all payments are made within four years from the date of original purchase of such contract.

If a husband pays interest on an indebtedness of his wife, he cannot claim it on his individual return, and she may not claim it on hers, because it was not paid by her. It could be taken on a joint return, however.

II. STATE OF WISCONSIN

New Rulings and 1952 Changes

1. Wisconsin Dividends. Formerly, dividends received from Wisconsin corporations and included in income were deductible. Effective January 1, 1952, no dividends received after such date will be deductible.

2. Entertainment Expenses. The Wisconsin Board of Tax Appeals recently considered the question of deductibility of entertainment expenses by physicians. The taxpayer was a specialist, 70 per cent of whose practice was made up of referrals from general practitioners.

He entertained members of the medical profession and others to establish and maintain good will and increase his business. For the most part this was done in his own home. He joined a golf club and, during the holiday season, made gifts to the nurses, interns and other hospital personnel. For all of these expenses he kept an accurate accounting. The success of the taxpayer's plan was shown by the doubling of his income within a few years.

The Board of Tax Appeals held the Code of Ethics of the medical profession was the proper guide as to what is the *ordinary* practice in the profession, rather than the testimony of other physicians. Therefore, the entertainment expense was not an *ordinary* expense of the medical profession, as required by the tax statutes.

Furthermore, as to golf club dues and green fees, the Board felt that the social aspects were too closely interwoven to allow deduction as ordinary and necessary business expense.

With regard to the gifts made to members of hospital staffs, the Board stated, "We dislike to feel that the gifts were offered or received as ordinary and necessary expenses of doing business."

It may be that the apparent effect of this decision will be softened by a subsequent case. Until such time, however, the rulings set forth above should be heeded.

General Instructions

Returns of 1952 state income must be made to the assessor of incomes of the district in which the taxpayer resides, on or before March 15, 1953. A written extension of the time in which to file may be granted for sickness or other sufficient cause by the assessor of the department of taxation for the district in which the taxpayer lives. Such extension must be on written request, may not exceed thirty days, is discretionary in the assessor, and will not be granted because of mere neglect of the taxpayer.

Liability to Make Tax Return

Every resident must file a return whether notified to do so or not, if:

(1) He is single and his net taxable income is $800 or more.

(2) He is married, and his net taxable income, combined with that of his spouse, is $1600 or more.

(3) His gross receipts for the year total $4,000 or more, regardless of the amount of net income.

If the status of the taxpayer changes during the taxable year, insofar as it affects personal exemption for husband and wife, head of family, or dependents, such personal exemption shall be apportioned in accordance with the number of months before and after such change, disregarding a fractional part of a month unless it amounts to more than a half month, in which case it shall be considered as a month.

Every person having a legal residence in Wisconsin and every other person maintaining a permanent place of abode here, or spending in the aggregate more than seven months of the income year within the state, shall be deemed to be residing in Wisconsin for purposes of determining liability for income taxes and surtaxes. When a person changes his permanent residence to or from Wisconsin during the year, liability to taxation for income which follows residence shall be determined on the basis of the income received during the part of the year such person was a Wisconsin resident. Personal exemptions are prorated on the basis of time of residence within and without the state.

Minors

Minors, regardless of age, or their guardians, whether natural or appointed, must file a return reporting all income if they fall within the classifications set forth in this article, on this page, under the heading "Liability to Make Tax Return," except that,

(1) if the child is under 18 years of age, the *earned* income of the child *shall* be added to that of the husband or father, or if he be not living, to that of the head of the family, provided the child and the father or head of family be residing together as members of a family.

(2) unearned income of the child *may*, to the extent made available to and used by a parent in the discharge of his natural obligation to support the child, be added to that of the parent.

The personal exemption allowable to the minor or guardian shall be the same as any other person, except that if the minor is actually supported by and dependent upon a natural person for his actual support so that such natural person is entitled to a personal exemption for such minor, the personal exemption of the minor or guardian shall be reduced by $4.00.

Income Tax Rates

The normal tax, which is graduated, varies from 1 per cent on the first $1,000 of net income to 7 per cent on net incomes in excess of $12,000. The teachers' retirement fund surtax is based on one sixth of normal taxes after deducting $37.50 from the net normal tax. The 25 per cent surtax enacted by the 1949 session of the Legislature is no longer in effect, not having been renewed by the 1951 Legislature.

Income from United States Taxable

All wages, salaries or fees derived from personal services, including services performed for the United States or any agency or instrumentality thereof, are now taxable. Compensation for active military service or reserve service is exempt for the year 1952.

Capital Gains and Losses

Full gains or full losses are recognized irrespective of the time the asset was held. However, gains on real estate sales may be reported on the installment basis, provided *less than* 30 per cent of the sales price is received during the first contract year.

Annuity Rule

As distinguished from the federal rule governing annuity income, the Wisconsin rule provides that annuity payments under an endowment or annuity contract are income to the extent of any payment *after* the income tax cost (aggregate premiums or consideration) has been recovered. However, when the contract provides for the separation of the periodic payment into principal and interest, the interest so received is taxable when received.

Optional Return

An optional "short form" return may be filed. The return is similar to the federal "short form" return. The form may be used only if all the following conditions are met:

(1) Gross receipts of the income year may not exceed $5,000.

(2) Report must be made on the calendar year basis.

(3) Report must be on the cash basis and such basis would clearly reflect taxable income were the optional method not elected.

(4) Inventories are not required in the determination of taxable income.

(5) Wisconsin residence must have been maintained for the full year.

(6) If both husband and wife are required to file returns, each spouse must elect to file on the optional basis for the same year.

Inasmuch as most physicians will not be eligible to file the "short form" return due to not being able to meet all of the above conditions, no further discussion of this form will be attempted. All subsequent portions of this article are set forth on the assumption a "long form" return is being filed.

Limits on Federal Tax Deduction

The deduction for *all* United States income taxes shall be limited to a total amount not in excess of 3 per cent of the taxpayer's net income computable without the benefit of the deduction for such federal taxes, and *before* the deduction of contributions:

Example: The taxpayer's net income, for purposes of the Wisconsin return, before deduction of any United States taxes paid during 1952 and before deduction of contributions, is $5,000. He paid federal income taxes of $400 during 1952. Under the above limitation he could deduct only 3 per cent of $5,000, or $150 for federal taxes, although he had actually paid $400. This has the effect of subjecting a larger part of the taxpayer's net income to the Wisconsin law, even though the normal rates as such have not been increased.

Instructions on the Filing of Separate Income Tax Returns for Husband and Wife

The rules of the Department of Taxation provide:

1. If a wife has a separate income of her own and the husband and wife may not or do not elect to file a joint return on the optional tax form 1a, she must file a separate return on form 1W or optional tax form 1–Wa. In case she has no income, no return need be filed.

2. In the event that both husband and wife have income and file separate returns, the personal exemption of $17.50 for the head of a family may be divided between the two according to their own choice, that is to say, the husband may claim it all, or the wife may claim it all, or they may divide it between them as they see fit.

3. The earned income of children under 18 years of age shall be included in the return of the husband, widow or head of a family, and the personal exemption for such children or dependents shall be allowed to the husband or may be divided between him and his wife as they may elect, or shall be allowed to the widow having such children. The exemption allowed to the head of a family, other than a widow or widower, supporting children under the age of 18 shall be limited to a deduction of $17.50 from the tax.

Personal Credits and Exemptions

The statutes themselves are so clear as to personal exemptions, credits for dependents, and the date determining the personal status of a taxpayer for income tax purposes that they are quoted here in full.

"71.03 (2) **EXCLUSIONS.** There shall be exempt from taxation under this chapter the following:

(a) Pensions received from the United States.

(b) All inheritances, devises, bequests and gifts received during the year.

(c) All insurance received by any person or persons in payment of a death claim by any insurance company, fraternal benefit society or other insurer, except insurance paid to a corporation or partnership upon the policies on the lives of its officers, partners or employes."

"71.09 (6) There shall be deducted from the tax after the same shall have been computed according to the rates in section 71.09 (1), a personal exemption for natural persons as follows:

(a) For an individual, eight dollars.

(b) For husband and wife or head of a family, seventeen dollars and fifty cents. For the purposes of this chapter, the term 'head of family' means a natural person who maintained a household and supported therein himself and one or more persons who were dependent upon him for support; but no additional exemption shall be allowed for those dependent upon the head of a family except in case of a widow or widower supporting children under the age of eighteen years.

(c) For each child under the age of eighteen years who is actually supported by and dependent upon the taxpayer for his support, an additional four dollars.

(d) For each additional person, except persons defined in section 71.09 (6) (c), who is actually supported by and dependent upon the taxpayer for his support an additional $4, except in case of head of a family. In computing taxes and the amount of taxes payable by persons residing together as members of a family, the earned income of each child under 18 years of age shall be added to that of the husband or father, or if he be not living, to that of the head of the family and assessed to him except as hereinafter provided. The taxes levied shall be payable by such husband or head of the family, but if not paid by him may be enforced against any person whose income is included within the tax computation.

(e) If the status of the taxpayer, insofar as it affects the personal exemption for husband and wife, head of family and/or dependents, changes during the taxable year, the personal exemption shall be apportioned, under rules and regulations prescribed by the department of taxation, in accordance with the number of months before and after such change. For the purpose of such apportionment a fractional part of a month shall be disregarded unless it amounts to more than a half month, in which case it shall be considered as a month."

Deductions

A. Statute

The statute setting forth what constitutes allowable deductions of major items of expense is so clear that portions of it are reprinted here as an aid to physicians in making state returns:

"71.05 Deductions from Incomes of Persons Other Than Corporations. Persons other than corporations, in reporting incomes for purposes of taxation, shall be allowed the following deductions:

(1) Payments made within the year for wages or other compensation, if reasonable in amount, for services actually rendered in carrying on the profession, occupation or business from which the income is derived. But no deductions shall be made for any amount paid for services actually rendered in the carrying on of the profession, occupation, or business from which the income is derived unless there be reported the name and address and amount paid each person to whom a sum of $700 or more shall have been paid for services during the assessment year. Except as provided in subsection (9) of this section, no deduction shall be allowed under this section for any amounts expended for personal, living, or family expenses.

(2) The ordinary and necessary expenses actually paid within the year in carrying on the profession, occupation, or business from which the income is derived, including a reasonable allowance for depreciation by use, wear, and tear of the property from which the income is derived, and in the case of mines and quarries an allowance for depletion of ores and other natural deposits on the basis of their actual original cost in cash or the equivalent of cash. Provided, however, that no deduction shall be allowed for rent paid unless the payor reports the amount so paid together with the names and addresses of the parties to whom rent was paid.

(3) Interest paid within the year on existing indebtedness; provided, the debtor reports the amount so paid, the form of the indebtedness, together with the name and address of the creditor. But no interest shall be allowed as a deduction if paid on an indebtedness created for the purchase, maintenance or improvement of property, or for the conduct of a business, unless the income from such property or business would be taxable under this chapter.

(4) Taxes other than inheritance and special improvement taxes upon the property or business from which the income hereby taxed is derived paid by such persons during the year, including therein taxes imposed by the state of Wisconsin or the United States government as income taxes; provided, that such portion of the deduction for federal income taxes as may be allowable shall be confined to cash payments made within the year covered by the income tax return; and provided further, that deductions for income taxes paid to the United States government shall be limited to taxes paid on net income which is taxable under this chapter; and provided further that income taxes imposed by the state of Wisconsin shall accrue for the purposes of this subsection only in the year in which such taxes are assessed.

(4a) The deduction for all United States income, excess or war profits and defense taxes shall be limited to a total amount not in excess of 3 per cent of the taxpayer's net income of the calendar or fiscal year as computed without the benefit of the deduction of said United States income, excess or war profits and defense taxes, and before the deductions of amounts permitted by subsection (6) of this section. In no event shall any taxpayer be permitted hereunder a total deduction in excess of the actual amount of United States income, excess or war profits and defense taxes paid, and otherwise deductible.

(6) Contributions or gifts made within the year to any corporation or association organized and operated exclusively for religious purposes, to any national organization of veterans of the armed forces of the United States or subordinate unit thereof, or to the state or any political subdivision thereof for exclusively public purposes, or to any corporation, community chest fund, foundation or association operating within this state, organized and operated exclusively for charitable, scientific or educational purposes, or for the prevention of cruelty to children or animals, no part of the net income of which inures to the benefit of any private stockholder or individual, to an amount not in excess of 10 per cent of the taxpayer's net income of the calendar or fiscal year as computed without the benefit of this subsection.

(7) Amounts contributed for the given period to the unemployment reserve fund established in section 108.16 of the statutes, but not the amounts paid out of said fund.

(8) Losses actually sustained within the year and not compensated by insurance or otherwise, provided that no loss resulting from the operation of business conducted without the state, or the ownership of property located without the state, may be allowed as a deduction, and provided further that no loss may be allowed on the sale of property purchased and held for pleasure or recreation and which was not acquired or used for profit, but this proviso shall not be construed to exclude losses due to theft or to the destruction of the property by fire, flood or other casualty. No deduction shall be allowed under this subsection for any loss claimed to have been sustained in any sale or other disposition of shares of stock or securities where it appears that within thirty days before or after the date of such sale or other disposition the taxpayer has acquired (otherwise than by bequest or inheritance) or has entered into a contract or option to acquire substantially identical property and the property so acquired is held by the taxpayer for any period after such sale or other disposition. Reserves for contingent losses or liabilities shall not be deducted.

(9) Payment for expenses for hospital, nursing, medical, surgical, dental, and other healing services and for drugs and medical supplies incurred by the taxpayer on account of sickness or of personal injury to himself or his dependents in excess of $50 but not more than $500.

(10) Any and all sums not to exceed $800 paid by any person by way of alimony to a former spouse, but any person claiming a deduction under this subsection shall not be allowed a personal exemption for his former spouse under section 71.09 (6) (d).

(13) (a) In lieu of the deductions allowed in this section for interest paid, other than interest paid on indebtedness incurred to carry on a profession or business from which taxable income is derived, Wisconsin income taxes, United States income taxes, "deductible" dividends, contributions, medical expenses, dues to labor unions and professional societies and the deductions permitted in subsection (10), there shall be allowed to natural persons an optional standard deduction equal to 9 per cent of gross income, but in no case to exceed $450.

(b) The election by a taxpayer to take his deductions on an itemized basis or to take the optional standard deduction for any year shall be irrevocable. If the gross income as shown on the return is subsequently adjusted, the amount of the optional standard deduction shall be adjusted accordingly within the limits prescribed by paragraph (a).

(c) In the case of husband and wife, the optional standard deduction shall not be allowed to either if the net income of one of the spouses is determined without regard to the optional standard deduction. For the purposes of this subsection the determination of whether an individual is married shall be made as of the close of his taxable year.

(d) In the case of a taxable year of less than 12 months on account of a change in the accounting period, the optional standard deductions shall not be allowed."

B. Expenses Incurred in the Earning of Salaries

Taxpayers who incur deductible expenses in the earning of salaries, wages, fees, and commissions may deduct these expenses from their gross salaries, wages, fees, and commissions and also elect to take the optional standard deduction. Unlike the federal rule which allows employees to deduct "business expenses," in addition to the standard deduction, only if they fall within the term "traveling expenses" or are reimbursed expenses, Wisconsin allows any deductible expenses, in addition to the optional standard deduction, provided it be incurred in the earning of the salaries, wages, etc.

Both the gross amount of the compensation and the total of such expenses should be shown at line 1, page 2 of the return and only the net amount should be extended into the money column.

These expenses are not deductible if the optional "short form" is used.

C. Index to Deductions

This index is designed to assist the physician in ascertaining what deductions are allowable. The number given after each heading refers to the paragraph numbering on the pages following. The paragraphs explain in detail what deductions and depreciation are allowable.

Automobiles, 1.
  Depreciation.
  Driver, 1.
  Insurance, 1, 3.
  Maintenance.
  Professional use.
  Repairs.
Bad debts, 2.
Bandages, 8.
Conventions, 7.
Contributions and gifts, 15 (f).
Depreciation.
  Automobiles—20 per cent annually of cost price, 1.
  Instruments, 8.
    10 per cent annually of cost price of surgical instruments and general equipment; 10 per cent on x-ray equipment.
  Medical library, 5.
    10 per cent annually of cost price.
  Office equipment, 10.
    10 per cent annually of cost price.
Dues, 11.
Equipment. Rate must be reasonable.
  Office, 9.
  Professional, 8, 15 (a).
Fire, loss by, 6.
Instruments, 8.
Insurance premiums, 3.
  Automobile, 1.
  Hospital and surgical, 15 (g).
  Malpractice, 3.
  Professional equipment, 3.
Interest paid, 4.
Laboratory materials, 8, 15 (a).
Legal expenses, 15 (b), 15 (d).
Library, 5.
Licenses, 12.
Losses, by fire, flood, theft, suit, etc., 6, 15 (d).
Medical convention, 7.
Medical expense, 15 (g).
Medical Society group health and accident annual premium, deduct $17. See 15 (g).
Medical supplies, 8.
Miscellaneous, 15.
Office expenses, 9.
  Heat, light, supplies, telephone, water, short-lived office equipment, annual depreciation on furnishings and fixtures.
Office rental, 10.
Postgraduate studies, 13.
Professional conventions, 7.
Professional dues, 11.
  American Medical Association.
  County Society.

State Society.
Special societies as:
American College of Surgeons.
American College of Radiology.
Any other paid in interest of profession.
Professional subscriptions, 5, 11.
Salaries, 14.
Sale of spectacles, 15 (c).
Scientific meetings, 13.
Subscriptions, 5.
Taxes and licenses, 12.
Automobile licenses.
Federal income—3 per cent maximum.
Import duties, etc.
Personal property taxes.
Professional license fees.
Real property taxes on office owned and used by taxpayer in practice.
Social security taxes.
Wisconsin income taxes and surtaxes paid.
Wisconsin unemployment taxes.
Theft, loss by, 6.
Traveling expenses, 7, 13.
Both professional calls and scientific meetings.
Wages and salaries, 14.
Clerk, 14.
Driver, 1.
Laboratory assistant, and technicians, 14, 15 (a).
Maid, 14.
Nurse, 14.
Stenographer, 14.
Any other employe rendering service in connection with taxpayer's practice or in the care and treatment of patients, 14.

D. Explanation of Deductions

In numerous instances below, references are made to numbered paragraphs of the federal portions of this tax summary. These will be found on pages 1213 to 1216 of this article. Where the text on federal taxes is equally applicable to Wisconsin returns, reference is made to the former so as to avoid needless repetition. Where the explanation applicable to Wisconsin income taxes varies from the federal, such explanation is separately given in the paragraphs following.

1. Automobiles. (See paragraph 1, page 1213).

For Wisconsin income tax purposes, the cost price for an automobile, or other business property, acquired on a trade-in of a similar asset is the list price of the asset, regardless of whether it was an outright purchase or a trade-in deal. The Wisconsin rule is in this respect different from the federal rule.

2. Bad debts. (See paragraph 2, page 1214).

3. Insurance Premiums. Premiums paid for insurance against professional losses are deductible. This includes insurance against damages for alleged malpractice, against liability for injuries by a physician's automobile while in use for professional purposes, and against loss from theft of professional equipment, and damage to or loss of professional equipment by fire or otherwise. This further includes premiums for various forms of insurance on the building owned and used in connection with the practice, or a fair proportion thereof where the building is also a home. Under professional equipment is to be included an automobile belonging to the physician and used partially or wholly for professional purposes.

4. Interest Paid. Interest paid within the tax year on existing indebtedness may be deducted, provided that the debtor reports the amount so paid, the form of indebtedness, and the name and address of the creditor. No interest is allowed as a deduction if paid on indebtedness created for the purchase, maintenance or improvement of income producing property, or for the conduct of a business, unless the income from such property or business would be taxable under the Wisconsin law.

Interest paid on state and federal income taxes is deductible, but interest paid on fines levied for violations of law is not allowable as a deduction.

Interest paid by an individual on indebtedness created for the purpose of acquiring a home is deductible from gross income. Likewise, interest paid by an individual on money borrowed to pay personal debts, such as hospital bills and other family obligations, is considered a proper deduction from gross income.

Interest paid by an individual on money borrowed for the purpose of securing an education is allowable even though other expenses of obtaining such education are not allowable.

5. Library. A fair rate of depreciation on the physician's library may be deducted covering wear and tear sustained through use. In determining the rate, however, obsolescence may not be considered since the Wisconsin income tax law does not recognize losses in value due to such causes. The fact that medical books become out of date during the course of ten years cannot be considered in determining the rate of library depreciation. An annual depreciation of 10 per cent of the cost of such library seems reasonable, however.

Costs of subscriptions to scientific medical journals essential to keep the physician abreast with the progress of his profession are deductible.

6. Losses by fire, etc. Loss of and damage to a physician's equipment and other property, used by him in connection with carrying on his professional practice, by fire, theft or other cause, not compensated by insurance or otherwise recoverable, may be computed as a business expense, and is deductible, provided evidence of such loss or damage can be produced. Such loss or damage is deductible, however, only to the extent that it has not been made good by repair and cost of repair claimed as a deduction. Losses on business conducted or property located outside the state are not deductible.

Losses on automobiles, aircraft, summer homes, motor boats, furniture, etc., purchased and held for

pleasure are deductible from gross income where sustained because of theft, fire, flood, or other casualty. Losses on property used for both pleasure and practice are deductible only to the extent that such property was used in the practice, unless such losses were sustained through fire, flood, other casualty, or theft, in which cases the entire loss is deducted.

7. Medical Conventions. Ordinary and necessary expenses incurred in attending medical conventions or professional scientific societies, necessary to enable the physician to carry on his profession, are deductible.

Costs of attending professional conventions must be strictly limited to the necessary cost and expense directly attendant upon such conventions. The type of professional convention here contemplated is confined to such as are, as a general rule, ordinarily and generally attended by persons of the same professional standing as the taxpayer, as necessary to the maintenance and carrying on of their regular practice and profession.

8. Medical Supplies and Instruments (See paragraph 4, p. 1214.)

9. Office Expenses (See paragraph 5, p. 1214).

10. Office Rental. If a physician pays rent to another person for office space he is permitted to deduct the amount from his gross income. This includes office space in a rented home, provided office hours are maintained. Where a physician maintains his offices in the home which he occupies as a residence, he may, if the home is rented, deduct as rent that proportion of the total rent paid which the value of his office space bears to the rental of the entire premises; and if he owns the residence, he may deduct the proper share of expenses attributable to the space so occupied, including taxes, depreciation, insurance, water, light, heat, repairs and general upkeep.

11. Professional Dues and Subscriptions (See paragraph 7, p. 1214).

12. Taxes and Licenses. All taxes and licenses incident to the professional scope of the physician may be deducted. The following taxes would be deductible by any physician:

(a) Real property taxes paid on office owned by him and used by him in his practice.
(b) Personal property taxes paid on his apparatus and equipment.
(c) Wisconsin income taxes and surtaxes paid.
(d) Federal income taxes, provided that such deductions are limited to taxes paid in cash within the year covered by the income tax return on net income taxable under the Wisconsin law, the maximum deduction not to exceed 3 per cent of net income computed under the state law *before* contributions.
(e) All license fees incident to his profession.
(f) Automobile licenses on automobiles used exclusively in the practice of his profession. See paragraph 1 supra.
(g) Import or tariff duties and business, license, privilege, excise, and stamp taxes, are deductible if incurred in connection with the carrying on of the taxpayer's practice and profession.
(h) All social security taxes paid by the physician in his capacity of employer and the amount paid by him under the Wisconsin unemployment compensation act. A salaried physician is required to include the amount of the social security tax paid by him in determining his gross salary. He is then permitted by the same rule to deduct the amount of the social security tax withheld from him and to include it as part of his federal income tax, subject to the 3 per cent maximum rule noted in subhead (d) above.

Taxes which are not deductible include: Real estate on residence property occupied by the owner; automobile license fee, gasoline, cigarette and amusement taxes, inheritance taxes, special assessment taxes; and taxes on vacant lots. However, doctors, traveling salesmen and others who use their automobiles in the production of their income may include the gas tax, and auto license fee as a part of the cost of operating the automobile.

13. Traveling Expenses (See paragraph 9, page 1214).

14. Wages and Salaries (See paragraph 10, page 1214 and 15 (e) below.

15. Miscellaneous.

(a) Laboratory Expenses (See paragraph 11 (c), page 1215).
(b) Legal expenses incurred in the defense of a suit for malpractice are deductible as business expenses. Expenses incurred in the defense of a criminal action, however, are not deductible.

Legal expenses incurred in connection with the operation of a taxpayer's profession are proper deductions unless such business is conducted in violation of the law.

(c) Sales of Spectacles (See paragraph 11 (e), p. 1215).
(d) Unclassified. Payments required to be made to others for damages growing out of the carrying on of the profession such as injury to property, interference with property rights, breach of contract, and libel are deductible from gross income. Damages of a personal character recovered against the physician, such as those for the surrender of the custody of a minor child, are not deductible from gross income because not related to the carrying on of the physician's profession.

Miscellaneous expenses which are incurred in producing taxable income and are allowable deductions include the following: fees paid to auditors, tax experts, and lawyers in connection with income tax matters, welfare work expense incurred in keeping up the morale in an office and organization.

(e) Informational Returns. All salaries, wages, fees, or other compensation for services actually rendered in connection with the physician's practice which total or exceed $700 in the case of any individual recipient, must be reported or such expense shall not be deductible. This information, which must disclose the name, the address and the amount paid each such person, can either be furnished as a part of the income tax return or reported on form 9A, which form will be furnished the physician by the income tax assessor on request. Similar information must be furnished either on the return or on form 9A which should accompany the return, where deduction is sought on items of rent, royalty and interest expense.

(f) Contributions or gifts made to public, religious, educational, charitable, veteran's, or other groups listed in section 71.05 (6), Wisconsin Statutes, 1951, quoted on page 1218 of this article are deductible to an amount not in excess of ten per cent of the taxpayer's net income for the fiscal or calendar year.

(g) Medical expenses—payments in excess of $50 but not over $500 for hospital, nursing, medical, surgical, dental services and medical supplies incurred by the taxpayer on account of illness or of personal injury to himself or his dependents.

Premiums for policies which pay hospital, surgical, medical, and related benefits are likewise deductible, as is that portion of the total premium of a health and accident policy which represents such benefits. Such premiums are deductible whether the benefits are payable directly to the source of service, or as indemnity to the insured physician. Premiums for disability or time loss insurance, and for accidental death and dismemberment, are *not* deductible, however. Physicians enrolled in the Provident Life & Accident Insurance Company group disability and hospitalization plan, which has been carried through the State Medical Society since August 15, 1950, may deduct the hospital benefits portion of the annual premium, which is $17.

Importance of Adequate Accounting Records

It is equally true under both the federal and the Wisconsin laws that a properly maintained set of double-entry accounts is probably the greatest single means of facilitating the preparation of a physician's income tax returns, and of enabling him to secure the maximum advantage from the exemption and deduction statutes. Such a bookkeeping system is neither complicated nor unreasonably time consuming. It can be installed by any competent accountant at a reasonable cost, and can be maintained by any trained bookkeeper. A large number of tax complications would never arise if adequate accounting records were available to serve as the basis of tax returns, or as the authority for settling questions at an early stage.

THE NEW ORLEANS GRADUATE MEDICAL ASSEMBLY

The sixteenth annual meeting of The New Orleans Graduate Medical Assembly will be held March 2–5, headquarters at the Municipal Auditorium in New Orleans.

Eighteen outstanding guest speakers will participate and their presentations will be of interest to both specialists and general practitioners. In addition, the program will include a symposium on "The Value of Newer Drugs," daily demonstrations of medical and surgical procedures in color television, clinicopathologic conferences, medical motion pictures, over 100 technical exhibits, and three round-table luncheons.

The Assembly has planned another interesting postclinical tour to follow the 1953 meeting in New Orleans. On Saturday, March 7, a party composed of doctors and their families will leave New York for Europe on the great new superliner, S. S. United States. The itinerary includes England, France, Switzerland and Italy, and arrangements have been made for medical programs in these countries. The tour ends in Rome and the group will return to New York on March 31 by Pan American World Airways, President Special.

Details of the New Orleans meeting and the postclinical tour are available at the office of the Assembly, Room 103, 1430 Tulane Avenue, New Orleans 12, Louisiana.

Minutes of the Council Meeting, Milwaukee October 5 and 6, 1952

1. Call to Order

The Council was called to order by Chairman Arveson at 8:15 p.m., Saturday, October 5, 1952, at the Hotel Schroeder, Milwaukee.

2. Roll Call

Councilors present were Doctors Costello, Hemmingsen, Kasten, Dessloch, Heidner, McCarey, Fox, Bell, Kidder, Arveson, Ekblad, Galasinski, Bernhart, Wegmann, Zellmer, Past President Christofferson, and Chairman Emeritus Gavin.

Also present were President-Elect Griffith; Treasurer Weston; Speaker Tenney; Vice-Speaker Stovall; Dr. C. N. Neupert, state health officer; Dr. Gunnar Gundersen, Board of Trustees, American Medical Association; Dr. D. H. Witte, delegate to the American Medical Association; Dr. L. O. Simenstad, alternate delegate to the American Medical Association; Dr. J. S. Supernaw, chairman of Veterans Medical Service Agency; Dr. R. E. Fitzgerald, chairman, Grievance Committee; Dr. Roger Kennedy, president, Minnesota State Medical Association; and Dr. R. M. Moore. Present Sunday only were Dr. F. J. Elias, AMA delegate and past president, Dr. A. O. Swenson, chairman of the council, Dr. O. J. Campbell, president-elect and Mr. R. R. Rosell, executive secretary, all of the Minnesota State Medical Association; Dr. G. W. Carlson, Dr. K. H. Doege; and the following members and representatives of the State Board of Health: Doctors S. L. Henke, W. T. Clark, C. D. Neidhold, Forrester Raine, Stephen Cahana, Woodruff Smith, E. H. Jorris, and Miss Eleanor Bauhs and Mrs. Stella Faville.

Also present were C. H. Crownhart, secretary, R. T. Ragatz, assistant secretary, R. B. Murphy, legal counsel, T. J. Doran, claims director, Earl Thayer, director of public information, B. C. Ostby, field secretary; Mrs. Helen B. Supernaw, Miss Joan Pyre, and Miss Jean McGruer of the Society's office.

3. Letter from Selective Service Director

Chairman Arveson read the following letter of commendation for the work done by Dr. F. L. Weston as chairman of the Wisconsin Advisory Committee to Selective Service:

STATE HEADQUARTERS SELECTIVE SERVICE

2 October 1952

Dear Dr. Arveson:

At the time of your last annual meeting, I requested that you extend my appreciation to Dr. F. L. Weston, to the members of his Committee, and to his staff assistants for the service rendered to the Selective Service System by the Wisconsin State Advisory Committee.

Selective Service has since been called upon repeatedly by the Armed Forces to supply the doctors and dentists necessary for the maintenance of our expanded military establishment. The increase in the tempo of our operations, occasioned by these calls, has multiplied the burdens of the Advisory Committee.

I am convinced that whatever success we have achieved in the administration of our procurement program is due largely to the soundness of the advice received from the Committee and to the support offered by the members of your profession. I am confident that we shall continue to benefit by their advice and counsel and again wish to commend Dr. Weston and his associates for their valued assistance in the difficult problem of procuring professional military manpower.

Very truly yours,

/s/ BENTLEY COURTENAY
Lt. Colonel, JAG
State Director

4. Approval of Minutes

On motion of Doctors Fox–Galasinski, carried, the minutes of the meetings of November 17–18, 1951, February 23–24, 1952, and May 17–18, 1952 were approved.

5. Executive Committee

In July the Council approved a contemplated study made with regard to powers and limitations of an executive committee and a resolution to create such a committee was prepared for Council consideration.

After considerable discussion, motion was made by Doctor Christofferson, seconded by Doctor Zellmer, to create an executive committee of seven members, consisting of three members of the Council, the chairman of the Council, the chairman emeritus, the president-elect and the president of the Society, with a majority of the committee to have the authority to hold a regular session, and that $500 be appropriated to the committee for necessary emergency expenditures.

Further discussion of the matter resulted in the motion of Doctors Bernhart–Ekblad, carried, that the motion of Doctor Christofferson be reconsidered and that further consideration and study be given to the executive committee for action at a later date.

6. American Medical Education Foundation

On motion of Doctors Zellmer–Fox, carried, a resolution supporting this project, calling upon physicians to contribute annually to the Foundation in support of medical schools, and instructing the printing of periodic lists of contributors in the Journal was approved for submission to the House of Delegates. The resolution is printed in the House

of Delegates proceedings reported in another section of this issue of the Journal.

7. Student Loan Fund

On motion of Doctors Kidder–Christofferson, carried, a resolution instructing an immediate campaign to develop the Student Loan Fund of the State Medical Society to a more effective size was approved for submission to the House of Delegates. The resolution is printed in the House of Delegates proceedings reported in another section of this issue of the Journal.

8. Council Committee Reports

Mr. Crownhart, on behalf of the Interim Committee, submitted the following report:

Report of the Interim Committee

The Interim Committee held sessions Friday evening and Saturday morning, October 3 and 4, and several of the matters considered by it have already been reported to the Council.

It reviewed a number of matters of a routine character, and reports to the Council at this time its plans to meet in joint session with the Executive Committee of the Commission on Prepaid Plans and others to consider pending developments in the field of public assistance.

The Committee on Care of the Aged of the Legislative Council has concluded its recommendations to the Legislative Council and a number of these are expected to be presented for legislative action. Among them are proposals to create a Division on Chronic Diseases and Geriatrics in the State Board of Health which will be charged with developing educational programs relating to nutrition, physical examination, research, and rehabilitation as these matters relate to the aged and aging. In addition, the committee of the Legislative Council recommends a continuing study as to the costs of all medical, hospital, nursing, and other care extended to the aged with emphasis on the possibility of developing a program in which these health costs will be established on a uniform basis applicable to all areas of the state.

This is an involved field in which it would appear that the development of public assistance in these several fields on a statewide basis is imminent. In Minnesota legislative power has been granted Blue Cross and Blue Shield to enter into these fields, and this power is already a statutory grant to the State Medical Society of Wisconsin.

Because the legislature will be in session within a short period of time, it seems wise that full implications of the committee's report be considered at an early date and reported back to the Council at its November 1952 meeting.

Finally, the Interim Committee has requested the secretary to present the current "housing" problem of the State Society to the Council for further instructions.

The following other committee reports were presented and are printed in their entirety in the House of Delegates proceedings reported in another section of this issue of the Journal:

Committee on Blood Banks
Historical Committee
Polio Consultants Committee
School Health Committee
Committee on Venereal Diseases
Veterans Medical Service Agency Committee
Committee on Civil Defense
Committee on Military Medical Service

On motion of Doctors Galasinski–Costello, carried, the reports were accepted for submission to the House of Delegates.

9. Section Delegates

At the July meeting of the Council the chairman appointed a special committee of Drs. E. L. Bernhart, H. Kent Tenney, and H. E. Kasten, to study the matter of election of section delegates provided under the By-Laws, and to report its recommendations at the September meeting.

At the present time there are 10 sections and others will undoubtedly be created from time to time. The mechanism for the election of delegates has not been as definite as it should be and on some occasions the specialty sections themselves have actually taken over this function.

Doctor Bernhart, chairman of the committee, reported that a survey had been made of the procedure followed in some other states and that after study, the committee recommended that sections be directed to comply with the By-Law that membership requirements in sections be submitted to the Council for approval.

The committee further recommended that section delegates be without right to vote, but having all other privileges accorded delegates.

On motion of Doctors Ekblad–Galasinski, carried, the report was approved for submission to the House of Delegates.

10. State Board of Health

As president of the State Board of Health, Doctor Gavin introduced the members present and announced that the usual question and answer type of report from the Board of Health would be replaced with a forum type program, with reports from individual members of the Board.

A. Streamlining State Laboratory Services—Dr. S. E. Gavin—Doctor Gavin spoke briefly on the current program of modernizing state laboratory services which have been in effect in this state since 1917. He stated that as of the end of June 1953, the cooperative arrangement which the Board of Health has had with eight cities in which laboratories are now located will be withdrawn and that the branch laboratory at Rhinelander will be closed. The services performed for physicians throughout the state in aiding in the diagnosis of communicable diseases and examination of water supply samples will be taken over by the new State Laboratory of Hygiene at Madison. He said further that most of the cities will probably continue to operate their laboratories

for examination of milk, restaurant sanitation, etc., and that the cities say that since they have been paying 75 per cent of the bill anyway, this plan should improve efficiency of operation, settle troublesome administrative problems, and give the cities full local autonomy.

Doctor Gavin introduced Dr. W. D. Stovall, director of the State Laboratory of Hygiene, who supplemented his remarks with various reasons for removal of some of the laboratory services. He said that the eight cooperative laboratories originally were to handle problems of the cities and their surrounding areas; however, the work of tests and sanitation problems has become so great within the cities themselves that the additional work of communities outside cannot be handled. For that reason, and because it is difficult to enlarge these laboratories, it has seemed advisable to have them continue as city laboratories only. While the laboratories have dealt, for the most part, with diagnosis of diphtheria, and such things, it is now necessary to do an entirely different kind of laboratory job as far as communicable disease is concerned. For example, surveys regarding water supplies should be done regularly, rather than every six months, and this cannot be done in the smaller laboratories, because they simply do not have the facilities. Doctor Stovall said that with the introduction of the antibiotics and the control of disease through that medium, there is a change in the emphasis of the whole communicable disease picture, and that it is absolutely imperative in this state to give more attention to the problem of general sanitation.

B. Together We Tackle the Neonatal and Premature Birth Problems—Dr. Woodruff Smith—Doctor Smith spoke on the role of the State Board of Health in maternal and child welfare and the work of making obstetrics better in Wisconsin. The maternal death rate has decreased from 188 deaths per year in 53,000 births, to 42 per year in 88,000 births. At the same time, Doctor Smith pointed out, obstetrics has become more complicated and childbirth has become more complex for the normal mother, with extra tests, classes, and preparation. Doctor Smith said the premature death incidence has not gone down and, because the reasons are not known, this requires careful analysis. He stated that through their program of educating the public as to the importance of such things as nutrition and the ways of life of the mother in early pregnancy, it is hoped that some of the remaining problems will be solved.

C. Do We Have Enough Hospital Beds?—Dr. E. H. Jorris—Doctor Jorris reviewed the Wisconsin Hospital Plan which is based on information obtained from a hospital survey completed in 1946, and from additional data gained through supplementary surveys and experience in the operation of the plan during the past five years. It provides for minimum standards for construction, operation, and maintenance of hospitals, and recommends type, size, and location of facilities needed.

In the plan the State Board of Health has determined the general hospital service areas, total number of beds needed, and allocation of additional beds and future needs. In addition to general hospital needs, consideration must be given to public health centers, psychiatric units, chronic disease units, and public health centers.

Doctor Jorris said $1,500,000 is provided per year under the Hill–Burton Act, to be used for hospital construction, etc. A total of $29,000,000 has been spent since 1946 in the building of 32 general hospital units, with 1,324 beds, helping to finance such programs as the State Laboratory of Hygiene, etc. During the same period approximately the same amount has been spent for identical construction without the Hill–Burton funds, for the most part in areas which are well off economically. That means, Doctor Jorris concluded, that a total of about $60,000,000 has been spent for this type of aid in the last six years. One hundred seventy-five million dollars is needed for adequate provision of beds, equipment, etc., in all types of hospitals, and if the state can continue at the same rate as it has in the past six years, that is, at $10,000,000 a year, it will be well taken care of.

D. Should the Council and the Board be Concerned That There are Five Larger Cities in the State Without City Health Officers?—Dr. S. L. Henke—Doctor Henke reported that the state law requires full-time medical health officers in cities of 39,000 and over. At the present time there are vacancies in Eau Claire, Green Bay, La Crosse, Oshkosh, and Kenosha. He stated that, regarding non-medical officers, a study reveals that 30 per cent of the administrative duties are non-medical and only 3 out of the 48 states have non-medical health officers, that the work is best done by individuals with at least medical backgrounds, and that some universities now have special studies in public health.

Doctor Henke said the reasons for the vacancies are the scarcity of trained doctors and the salary differential between the public health officer and the physician in private practice. The average net income of a practicing physician is $11,898 and the average net income of a health officer is $8,000. However, the requirements for a health officer are one year of internship, licensure to practice medicine in the U. S. or Canada, six years of special training, including one year, School of Public Health and two years public health residency, full-time practice or teaching in public health, and membership in the AMA and APHA, which would actually make them specialists. Since preventive medicine must be constantly emphasized and since health departments have demonstrated their effectiveness, the physicians have a real stake in securing medical health officers. This can be done through higher salaries, interesting younger physicians early in their training, and the use of lay administrators, with at least a part-time physician as advisor; together

with the possibility of consolidating three or four counties or cities in one unit, or city-county units.

E. How Can We Get People to Change Bad Health Practices to Good Ones?—Dr. Carl Neidhold—Doctor Neidhold reviewed the history of health education and said that in 1917 a new philosophy of health education was formed in this country that knowledge about health would not in itself result in practices which would maintain good health; but health education did not take any definite form in this country until the late Dr. Emmet Holt formed the American Child Health Association. It was thought that by educating the child in the school to good health habits the child would take the information home and educate the whole family.

In 1922 The American Public Health Association was actually organized and formed its section on public health education. Since that time the AMA and state societies have had active public health education programs in operation. Much has been accomplished, but there is still much to be done.

The program of the State Board of Health includes community organization directed toward the solution of local health problems; the providing of direct and advisory services on such things as the preparation, selection, distribution and use of news releases, publications, radio programs (such as the March of Medicine), health films, the integration of social hygiene in the home, church, school and community; and the promotion of school health activities.

Doctor Neidhold said that through cooperation and participation between the public and the health "experts"—the working out of programs with the public instead of just passing the information on—the dangerous gap between knowledge and practice can be bridged. The over-all objective is to influence people to change their bad health habits to make early diagnosis and treatment possible, and if this is successful the Board would like to propose legislation to secure health educator specialists to work in districts throughout the state.

F. Should We Be Especially Concerned about Sanitary Conditions in Rural Areas?—Dr. C. N. Neupert—Doctor Neupert said that, by and large, the sanitation program in Wisconsin is greater in the cities than in the rural areas because the cities have full-time health departments, and that there are some real, unmet needs in the sanitation program. He said that a great percentage of our rural schools have water supplies that are unsafe, or potentially unsafe, or have no water supply at all. The same percentage have inadequate or insanitary toilet facilities. Farm wells, recreational camps for children, and the rat problem in "city" dumps are some of the serious sanitation problems that are poorly met. He said if we are to meet even a part of these problems, it cannot be done without at least one district sanitation engineer in each of the health districts in the state, and he stressed the importance of local control. Doctor Neupert reported that the Board is asking the legislature for a trained sanitarian in each of eight of its nine districts.

Doctor Arveson thanked the members of the State Board of Health for their fine presentation to the Council.

11. Building Program

Mr. Crownhart presented the problem of inadequate space in the present quarters of the Society. The building now houses 51 employees in a space which should house only 30 to 35 individuals, and additional heavy IBM equipment is being purchased which will require space. With the probability of doubling the staff within the foreseeable future, it will be necessary to either make an addition to the present building or acquire new property on which to build adequate quarters. Slides were presented which showed how such an addition might be made and it was generally agreed that this would solve only the immediate needs and would not provide for future expansion or increases in staff. Other slides were shown which pictured property on Lake Monona on which an option had been taken and on which it was proposed a new building be erected. Mr. Murphy spoke briefly on the financing of the proposal. He stated there were no practical problems involved and that with total assets available and the right of WPS to make an investment within the limitations of the insurance laws, the State Medical Society could create a realty corporation to handle the program.

After several hours' discussion, and on motion of Doctors Christofferson–Ekblad, carried, authorization was given to proceed with the purchase of the Monona Bay property.

A roll call vote was taken and the motion unanimously passed.

12. Price–Taylor Program

The Price–Taylor program was established as an experiment, and in view of eight years of operation, the question now arises as to its future.

After detailed consideration of statistical information, experience, the problem of the local community, and the wishes of the local county medical society, all of which were fully documented and presented to the Executive Committee of the Commission on Prepaid Plans, it is the recommendation of the Commission that:

a. The present program be discontinued when it expires October 31, 1952, for the reason that sufficient time has elapsed to answer or to make available answers to the principal questions for which the program was originally established on an experimental basis in 1944.

b. A program be developed and offered by the State Medical Society which will embody the full payment concept and follow, in general, the structure of Wisconsin Physicians Service, although with lower surgical and other schedules of benefits, and which may include home and office calls, such program to be offered to low income groups only when approved by the

county medical society in the area, and whose members subscribe to it.

c. Such program be made available by the State Medical Society as long as the source of funds for the advance payment of premiums does not represent governmental or other subsidies.

d. The State Medical Society develop a system of post-payment of premiums, without interest, for those insureds who cannot furnish advance premiums.

On motion of Doctors Bell–Bernhart, carried, the recommendations of the Commission were approved.

13. Adjournment

The meeting adjourned at 10:00 p.m., Sunday, October 5, 1952.

C. H. Crownhart
Secretary

Approved:

R. G. Arveson, M.D.
Chairman of the Council

Minutes of the Council Meeting, Milwaukee November 22 and 23, 1952

1. Call to Order

The Council was called to order by Chairman Arveson at 9:00 p.m., Saturday, November 22, at the Milwaukee Athletic Club.

2. Roll Call

Councilors present were Doctors Costello, Hemmingsen, Hill (Sunday only), Kasten, Dessloch, Heidner, McCarey, Bell, Kidder, Arveson, Ekblad, Galasinski, Bernhart, Casper, Wegmann (Sunday only), and Zellmer.

Others present were President Griffith; Speaker Forkin; Vice-Speaker Fons; Dr. W. D. Stovall and Dr. D. H. Witte, AMA delegates; Dr. J. M. Sullivan, editorial director of the Wisconsin Medical Journal and chairman of the Committee on Public Policy; C. H. Crownhart, secretary; R. T. Ragatz, assistant secretary; R. B. Murphy, legal counsel; Miss Joan Pyre and Miss Jean McGruer, of the Society's office.

3. Approval of Minutes

Approval of the minutes for the July and October 1952 meetings was laid over until the February meeting inasmuch as they are to be published in the November and December issues of the Journal, which were not in circulation prior to the November 22 meeting.

4. Commission on State Departments

In its 1952 session the House of Delegates approved the Council's recommendation to abolish seven standing committees of the Society and two Council committees which served special fields of public health interest, and to create in lieu thereof a Commission on State Departments.

The following statement in explanation of the Commission on State Departments was adopted by the Council, on motion of Doctors Ekblad–Kasten, carried:

Commission on State Departments

Duties and Responsibilities—To be advisory to all state departments operating health care or public health programs and to advise the State Medical Society through the Council concerning such projects, that the Society may coordinate its own efforts, create cooperative programs, and develop consistent policies.

Chairman of the Commission on State Departments—The chairman shall be selected by the Council from nominees submitted by the chairman of the Council and the president of the Society.

Membership and Qualifications—The commission itself shall consist of a general chairman and nine physicians, to be chosen by the Council of the State Medical Society at its Annual Meeting in each year, such members to serve for terms of one year. Those initially chosen shall serve until March 1, 1954. Members of the commission shall represent general practice as well as the several specialties, and shall individually have interest in tuberculosis and chest diseases, rehabilitation, handicapped children, maternal and child welfare, mental hygiene and institutional care, school health, public assistance, geriatrics, hearing and visual defects, and others.

Organization—Each chairman shall select members of the Society to serve on his committee who have special interest in the fields represented by such committee, and shall submit his choices to the commission for approval. Through its chairman each committee shall report to the commission as a whole, which in turn shall file, at least annually, a report to the Council.

The commission shall have the power to discharge committees and to recreate and reassign activities and responsibilities as the need may be demonstrated.

Each committee of the commission shall have the authority to invite to its meetings in advisory capacity such other individuals as may be helpful to serve the purposes of the committee, representing either state or private organizations, such as the Hospital Association, Nursing Association, etc.

Nominations for chairmen of the nine subdivisions of the commission were made, and on motions of the councilors, duly seconded and carried, the following appointments were recorded:

Dr. J. D. Steele, Milwaukee—Tuberculosis and Chest Diseases
Dr. R. F. Purtell, Milwaukee—Maternal and Child Welfare
Dr. T. L. Tolan, Milwaukee—Visual and Hearing Defects
Dr. R. G. Piaskoski, Milwaukee—Rehabilitation
Dr. J. A. Schindler, Monroe—Geriatrics
Dr. E. H. Pawsat, Fond du Lac—School Health
Dr. H. W. Carey, Lancaster—Public Assistance
Dr. H. A. Sincock, Superior—Crippled Children
Dr. E. D. Schwade, Milwaukee—Mental Hygiene

On motion of Doctors Kasten–Kidder, carried, the appointments of the commission members were confirmed.

In accordance with the statement adopted by the Council respecting selection of a general chairman from nominations submitted by the Chairman of the Council and President of the Society and on motion of Doctors Zellmer–Hill, Dr. T. W. Tormey, Jr., Madison, was appointed chairman of the Commission on State Departments.

5. Report of the Committee on Public Policy

Dr. J. M. Sullivan, chairman of the committee, presented to the Council recommended changes in various health laws of the state. A summary of these recommendations follows.

Basic Science Board

It is proposed by the Committee on Public Policy that the description in the Statutes of the basic sciences be amended as follows:

> The "basic sciences" are anatomy, physiology, pathology, and *physical* diagnosis.

For the purpose of a basic science examination the word "physical" is inserted to make it clear that it is not intended that applicants be examined in such manner as to require training in all modes of diagnosis, such as spinal puncture, etc.

In keeping with the committee's objective to do away with obsolete material in the Medical Practice Act, it is also recommending the deletion of a provision respecting the expiration date of the first appointments under the law.

The Committee on Public Policy has been informed that the Basic Science section of the examination offered by the National Board of Medical Examiners is much more intensive than that offered by the Wisconsin Basic Science Board. Dean Hirschboeck of the Marquette Medical School, in particular, has recommended that the Wisconsin Basic Science Board be permitted to accept, in lieu of its own examination, the Basic Science section of the National Board examination. The committee has accepted this suggestion and has recommended a safeguard requiring that the National Board certification be accepted by the Basic Science boards of at least six other states.

The present Basic Science law permits an applicant for a Basic Science certificate to cause his examination in the basic sciences to be confined to "one organ or set of organs." The elimination of that provision is suggested because those who are treating the sick are actually concerned with the entire anatomy of the body, as well as the subjects of physiology, pathology, and physical diagnosis.

State Board of Medical Examiners

In the statute dealing with the State Board of Medical Examiners, the existing requirement that the Board be composed of allopaths, homeopaths, eclectics, and an osteopath is obsolete. While the Committee on Public Policy recommends that an osteopathic representative be retained on the Board, it recommends that the balance be doctors of medicine. There are more than 3,000 doctors of medicine in Wisconsin and about 175 osteopaths. The representation of the osteopaths on the Board is therefore more than realistic.

The committee recommends the appointment of the state health officer as secretary of the Board, inasmuch as he is in full-time public health administration, can maintain permanent records for and headquarters of the Board in Madison, and is readily and conveniently available for consultation and in a supervisory capacity. Under the present law the Board's office follows the location of whomever may be elected secretary. The committee is further recommending that the Board maintain its offices in Madison, so that important records will not be subject to possible loss or damage, as is the case when the records are periodically transferred from location to location. Furthermore, the attorney general is the Board's attorney and may more readily be consulted on behalf of the Board.

The Committee on Public Policy recommends that the State Medical Society and the Wisconsin Osteopathic Association be authorized to submit nominees for vacancies and that the governor may, *but need not*, make his appointments from such list of nominees.

The committee believes it necessary that applications for written examinations and for reciprocity should be promptly processed. While the State Board of Medical Examiners has met more frequently than the present law requires, the lag in licensing has been of consequence and caused considerable concern in various areas of the state. For this reason the committee is recommending that the Board meet quarterly, rather than annually, as presently required.

Licensure Requirements

The Committee on Public Policy of the State Medical Society recommends that the prohibition in Section 147.17, Wisconsin Statutes, 1951, against practicing without a license extend to those who "treat the sick," as that term is defined in the Basic Science Law. The present restriction applies to those treating "bodily or mental ailments or injuries of human beings." The term "treat the sick" is not only defined by statute, but has been inter-

preted by our courts and by the Wisconsin attorney general, and it is well understood. On the other hand, the present phraseology has not been adequately defined and has created a good deal of confusion. The committee recommends, therefore, that the substitution of the words "treat the sick" is necessary to clarify the licensure requirement.

The committee further proposes, in this amendment, that the requirements relating to the recording and filing of licenses with the county clerk of the county in which the holder practices, be eliminated. The requirement for annual re-registration accomplishes the identical purpose which the recording provisions of this section were designed to meet.

Application Requirements

The Committee on Public Policy recommends that the State Board of Medical Examiners be provided with a statutory method for determining whether a medical or osteopathic college is, as the statute prescribes, substantially equivalent to the University of Wisconsin Medical School. Heretofore, no procedure has been established and it has been necessary for the Board to devise its own methods. The committee is recommending a provision similar to that recommended in the section applicable to licensure.

In keeping with the committee's objective to rid the Medical Practice Act of needless provisions, it proposes also the deletion of a provision which was made a part of the statute to permit one person, in the thirties, to become licensed.

Examination by the Board of Medical Examiners

The Committee on Public Policy considers it advisable to grant the Board of Medical Examiners more discretion in determining those subjects in which an applicant for licensure shall be examined. Many subjects now offered in medical and osteopathic colleges are not included among those now prescribed in this section. On the other hand, several of the subjects now prescribed for examination are adequately covered, at least in part, in the Basic Science examination. The committee has therefore concluded that the applicable section be amended to prescribe that applicants will be examined "in medicine and surgery and in such other subjects as are taught in professional colleges."

Licensure

The Committee on Public Policy recommends that the State Board of Medical Examiners be provided with a statutory method for determining whether the requirements for licensure in another state are equivalent to those in Wisconsin. Heretofore, no procedure has been established and it has been necessary for the Board to devise its own methods.

The committee further recommends that the reciprocity privilege now extended to surgeons of the armed services of the United States and of the Federal Public Health Service be limited to a period of one year following the date of such person's discharge from such service. It also recommends changing the phrase "army or navy" to "armed services" to include the air force as well.

The Committee on Public Policy is also recommending the deletion of obsolete material from the section concerning licensure.

Annual Re-Registration of Physicians

The Committee on Public Policy recommends the elimination of the present requirement contained in Section 147.15 (1) that a physician who changes location or opens an additional office notify the Board of such change. In view of the fact that registration is required annually, and that such registration discloses the change of location and the addition of an office, the provision imposes a needless burden upon the physician.

Under existing provisions, the State Board of Health is required to publish the names of those registered by the Board of Medical Examiners, and the Committee on Public Policy is proposing an amendment which would require each of the examining boards to publish the list of its registrants. It is certainly a duplication of effort for the Board of Medical Examiners to compile its list for certification to the Board of Health, and then to require the latter to publish the list. The Board of Medical Examiners has funds for this purpose, and the committee feels there is no purpose to be gained in seeking additional appropriations to the State Board of Health for this purpose.

Treatment of the Sick by Spiritual Means

In the prosecution of unlicensed practitioners, law enforcement officers are frequently met with the defense that the offender uses mental and spiritual means, in addition to physical modalities, in his offending practice. The practice of Christian Science is the only recognized form of treatment of the sick which employs mental and spiritual means exclusively, and the committee proposes amending the applicable statute, by deletion of material, to so provide.

State Medical Grievance Committee

The State Medical Grievance Committee under Section 147.195, Wisconsin Statutes, is charged with the investigation of practices of physicians that are inimical to the public health. It has the power to warn and reprimand and to institute actions against defenders. It has never had any appropriation of money to carry out its functions, and, because it is in a position to render a substantial service to the public health, the Committee on Public Policy recommends an appropriation of $1,500 for this committee.

The State Medical Grievance Committee consists of the state health officer, the secretary of the State Board of Medical Examiners, and the attorney general or deputy attorney general.

Because the Committee on Public Policy proposes that the state health officer be a member of the Board of Medical Examiners, it is suggested that the president of the State Board of Medical Examiners be substituted for the secretary.

The activities of the Grievance Committee would be facilitated substantially if it could call upon other branches of government to assist in the performance of its functions, and the Committee on Public Policy recommends the addition of a statement to the applicable section, authorizing cooperation of all divisions, officials, and employees of state and local government with the State Medical Grievance Committee.

Revocation of License

The following additional ground for the revocation of a license to practice medicine and surgery is proposed by the Committee on Public Policy:

> "Engaging in conduct unbecoming a person licensed to practice or detrimental to the best interests of the public."

Section 147.20 (1) sets forth in specific terms certain acts which constitute immoral or unprofessional conduct, and the committee is informed that it is desirable to add a general specification such as the above, into which would fall a number of offenses not now included. This particular phrase is common in medical practice acts of other states and has been helpful.

Restoration of License

Under section 147.20 (4), Wisconsin Statutes, 1951, provision is made for restoration of license under specified conditions, one of which is "written recommendation by the president of the State Board of Medical Examiners," . . . In order to place the responsibility of such recommendation on the entire Board rather than on one individual, the Committee on Public Policy is proposing the deletion of the words "by the president" from that section.

Voluntary Surrender of License

The State Board of Medical Examiners now accepts the voluntary surrender of a license. This procedure frequently avoids the embarrassment of a formal court action to the holder. The Committee on Public Policy recommends that this procedure be recognized by statute, and proposes an amendment for this purpose.

Practice of Midwifery

The Committee on Public Policy is informed that, for many years, the State Board of Medical Examiners has received no applications for examination and registration by one seeking to practice midwifery. It therefore recommends that the chapter relating to midwifery be repealed.

In view of the fact that there may be midwives practicing in this state, the committee proposes an amendment to Chapter 147 to permit a continuation of that practice for those already licensed.

Abortion and Miscarriage

The Legislative Council of the Wisconsin Legislature has undertaken a complete revision of Wisconsin's Criminal Code. It proposes the above amendment to those present sections of the statutes dealing with abortions and miscarriages.

Under the existing statutes a physician may perform a therapeutic abortion when that procedure is necessary to save the mother's life. He may not do so, however, if the fetus has not quickened. Were he to perform the procedure before quickening, he would have no defense against a criminal charge of causing a miscarriage.

In view of the fact that there appears to be no logical reason for the distinction, and because of the uncertainty as to when a fetus has quickened, the Committee on Public Policy has approved of this proposed revision.

An additional limitation has been placed upon a therapeutic abortion in this proposed revision. Unless an emergency prevents, the procedure must be performed in a licensed maternity hospital. The Committee on Public Policy is of the opinion that such a restriction is in no way objectionable.

Epileptics and the Marriage Laws

The Committee on Public Policy has been advised that, under the present statute, the Wisconsin courts would invalidate any marriage contracted between parties, one of whom was an epileptic prior to marriage. This would be true even though the fact of epilepsy were not discovered until after the marriage, and regardless of the fact that there existed no fraud or concealment on the part of the epileptic person.

The Committee on Public Policy concluded that only a legislative deletion of the words "or epileptic" in section 245.03 (1) would validate such marriages.

The committee was assisted in its deliberations by the Society's subcommittee on epilepsy and marriage, which advised that the present absolute restriction upon epileptic marriages is extreme, medically unrealistic, and ineffectual.

The proposal was approved by the Council and the House of Delegates by prior action.

Attention of the Council was directed by Doctor Bell to an article in the *Milwaukee Journal* dated November 23, 1952, in which a Cleveland physician was quoted as saying, "The State Medical Society of Wisconsin was wrong in trying to remove the Wisconsin ban against marriage of epileptics" because "heredity played a significant role in the disease."

The Council considered the statement and after discussion and on motion of Doctors Dessloch-

Zellmer, carried, it reaffirmed the action taken by the House of Delegates and itself respecting amendment of the law.

Tuberculosis Public Health Dispensaries

The statutes provide for establishment of public health dispensaries for tuberculosis "and other pulmonary diseases." The State Medical Society's Committee on Tuberculosis and Chest Diseases feels that inasmuch as the "free care" law is involved, the phrase "pulmonary diseases" is too broad and would take in such conditions as asthma, polio, and others not related to tuberculosis. It therefore recommends amendment of the section to read "tuberculosis or suspected tuberculosis" instead of "pulmonary diseases," and the Committee on Public Policy has accepted this recommendation.

Conclusion

In conclusion, the Committee on Public Policy reported its proposal to follow as a constant policy the legislative creed in Wisconsin, that its judgment on any legislative proposal be based on the philosophy that that which is in the interest of the public health must necessarily be in the interest of the medical profession.

On motion of Doctors Dessloch–Zellmer, carried, the Council accepted and approved the report of the Committee on Public Policy.

Mr. Crownhart also expressed the appreciation of the staff for the work done by the committee and reminded the Council of the action taken by the House of Delegates, in which it was directed that, through the committee, legislative proposals and amendments be brought before the county medical societies and discussed with physicians throughout the state. He stated that passage of proposed legislation would require the interest and active support of physicians, which can be promoted through such an educational and informative program.

6. Special Order—Appearance of Dr. S. P. Hurwitz

At his request, Dr. S. P. Hurwitz appeared before the Council to discuss the findings of the Wisconsin Board of Tax Appeals respecting deductibility of entertainment expenses by a physician for income tax purposes. Doctor Hurwitz reviewed the case, in which it was affirmed by the Board of Tax Appeals that the deductions taken on state income tax returns for such expenses would not be allowed, as they were in violation of the Code of Ethics of the profession. Doctor Hurwitz said he believed his ruling was contrary to the 1951 statement of the Judicial Council of the AMA to the effect that it is not unethical for a physician to make expenditures in connection with the entertainment of other physicians; he expressed his belief that the profession should, as a matter of principle, make a statement clarifying the action of the AMA, to the effect that entertainment, within reasonable amounts, of professional associates by a physician, is recognized as an ethical part of the economic phase of the practice of medicine.

On motion of Doctors Bernhart–Casper, it was directed that the Council of the State Medical Society support Doctor Hurwitz in his appeal of the recent decision by the Wisconsin Board of Tax Appeals.

After considerable further discussion, the above motion was formally withdrawn and on motion of Doctors Bernhart–Casper, carried, the following resolution was adopted:

WHEREAS, it has been suggested that it might be timely for the State Medical Society, through its Council, to express an opinion as to the ethical implications of reasonable expenditures made by a physician for the purpose of promoting his professional practice, now, therefore, be it

Resolved, that the Council of the State Medical Society of Wisconsin declare that in its judgment no violation of professional ethics is involved in expenditures which are reasonable in amount and which are made by a physician for the advancement and furtherance of the economic, as well as the professional, side of his practice, including therein entertainment by a physician of other physicians, consistent with the recent decision of the Judicial Council of the American Medical Association, which decision was ratified by the House of Delegates of the American Medical Association in December, 1951, and be it finally

Resolved, that such expenditures, in the judgment of the Council, do not in and of themselves fall within the advertising ban contained in the Code of Ethics of the American Medical Association.

7. Report of the Secretary

Mr. Crownhart submitted a list of 26 meetings attended by various members of the staff since the October Council meeting, and requested the Council to give consideration to the number of staff members it felt should be in attendance at its meetings.

The secretary also advised that in view of the action taken by the House of Delegates respecting the inclusion of representatives of the Woman's Auxiliary at Medical Society meetings, he would outline to the Auxiliary committee meetings in which they would have special interest and to which they would be invited.

The State Medical Society has been invited to participate in a student convocation of the Marquette University School of Medicine on January 14, to present various activities of the Society. Mr. Crownhart, in reporting the invitation, expressed appreciation for the opportunity afforded in this presentation.

The secretary advised that the establishment of a permanent program for medical and surgical care in Price–Taylor County had been contemplated. However, the Society has been advised by all those concerned that the extension of voluntary plans

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THE MEDICAL FORUM

SMS FORMS COMMISSION ON STATE DEPARTMENTS

New Projects Approved for Hill–Burton Grants

Washington, Nov. 10.—Three new hospital projects have been approved for Hill–Burton grants in the state of Wisconsin, according to Dr. Frank E. Wilson, of the AMA's Washington office.

A new, 34-bed hospital at Neillsville will replace a large frame house never designed for hospital use which has been that community's only facility. Reedsburg Municipal hospital is to have an addition affording 20 more beds, and a new Spooner Community hospital will add 20 beds in that area.

DR. T. W. TORMEY, JR.

Detroit MD Challenges Wisconsin Medical Society's Stand on Epileptic Marriages

Madison, Nov. 23.—The State Medical Society's stand on the marriage of epileptics has been challenged by a speaker at the recent meeting of the American College of Physicians in Chicago.

In October, the SMS House of Delegates passed a resolution favoring removal of the present ban on epileptic marriages. Their action was the result of studies by the Committee on Mental Hygiene, and was approved by the Council. The society plans to take the matter before the legislature in 1953.

Claims Heredity Significant

According to James C. Spaulding of the Milwaukee Journal staff, Dr. O. P. Kimball, former director of a special public school for epileptics in Detroit, claims that heredity plays a significant role in this disease. Dr. Kimball says that at least one third of the children in a family will be epileptics when one of the parents has the disease.

In a study of 294 Detroit families, 399 out of 1,070 children of epileptic parents had epilepsy, Dr. Kimball stated. In another 222 families in which neither parent was an epileptic but some other member of the family had the disease, there were 274 epileptic children. In four families with both parents epileptics, 20 out of 25 children were epileptics.

Society Discounts Factor

The Wisconsin society bases its discounting of the hereditary factor in epilepsy on the reports of such acknowledged experts as Dr. E. D. Schwade of Milwaukee, director of the Milwaukee county general hospital research clinic on convulsive disorders; Dr. Frederick A. Gibbs of Chicago and Dr. William A. Lennox of the Harvard university medical school.

Swedish Figure Lower

In contrast to Dr. Kimball's figure of about 36 percent heredity in epilepsy, these doctors who have studied more than 18,000 cases put the heredity factor in the disease at 1.5 to 2 percent. A recent six year study in Sweden places the figure even lower.

Madison, Nov. 24.—A new 10-member Commission on State Departments has been set up by the State Medical Society to provide medical guidance for activities conducted by various departments of the state government.

Dr. T. W. Tormey, Jr., Madison, is chairman of the new group.

Its members include Dr. John D. Steele, Milwaukee, who will be available for consultation on problems of tuberculosis and chest diseases; Dr. John A. Schindler, Monroe, geriatrics; Dr. Ray G. Piaskoski, Wood, rehabilitation; Dr. H. A. Sincock, Superior, crippled children; Dr. Robert F. Purtell, Milwaukee, maternal and child welfare; Dr. E. H. Pawsat, Fond du Lac, school health; Dr. H. W. Carey, Lancaster, public assistance; Dr. E. D. Schwade, Milwaukee, mental hygiene and Dr. T. L. Tolan, Milwaukee, visual and hearing defects.

Absorbs Duties

This commission absorbs the duties of nine separate committees which have long been advising as many departments. It was organized out of recognition of the fact that the functions of many of these committees, like those of the departments they have served, frequently overlap.

In announcing the appointment of the commission, Dr. R. G. Arveson, Frederic, chairman of the council, pointed out that a tuberculosis patient confined in a mental hospital would have been the concern of two separate committees before. Rehabilitation of TB patients interests both the State Board of Vocational and Adult Education and the Department of Public Welfare.

Similary the field of geriatrics crosses over into the field of public assistance and creates medical problems affecting the State Board of Health and the Department of Public Welfare. Visual and hearing defects are common to all age groups, often reaching into the fields of handicapped children and

(Continued on page 1234)

Admiral Boone Challenges Statements of Southern Medical Association's Leader

Washington, Nov. 17.—Admiral Joel T. Boone, chief medical director of the Veterans Administration, has directed an open letter of vigorous protest to Dr. R. J. Wilkinson, president of the Southern Medical Association, as a result of criticism of VA medicine alleged to have been made by Dr. Wilkinson before the 46th annual meeting of SMA at Miami, Florida November 10.

According to Dr. Boone, Dr. Wilkinson is quoted as saying "More and more VA hospitals are being erected each year at a staggering cost . . . notwithstanding the tragic and glaring fact that many of them are only partly filled and then only by veterans who are not rightfully entitled to this service."

Says Admiral Boone "The facts are that the Veterans Administration hospital construction program was authorized in 1946 and 1947 and has been progressing steadily toward completion since that time. No new hospitals . . . are being planned. In fact, the original authorization was reduced by some 16,000 beds.

"You are correct when you say some (not many) of these hospitals are only partly filled. This is partly because lack of appropriations . . . does not permit staffing and operating all beds in all hospitals. In some instances it is due to unfortunate hospital locations and inability to recruit in certain areas and categories.

"As for the statement that beds are "occupied by veterans who are not rightfully entitled to this service," I categorically deny the truth of this statement. The right of a veteran to hospitalization is established by law and not by whim. Every patient . . . is a veteran except for an infinitesimal number who are taken in for emergency treatment as a humanitarian act. . .

"Again you are quoted as saying "It is reported that approximately 90 percent of those treated have nonservice-connected disabilities, and many of these probably do not need hospitalization."

"Even the most "wild eyed" critics of the program have never claimed this . . . The exact figures are available . . . upon request to anyone who is interested enough to ask."

Admiral Boone has made public a breakdown in which VA patients are classified in ten categories. This list shows that 35 percent of patients are admitted for treatment of service-connected disabilities and another 11 per cent had such disabilities but were admitted for treatment of other disabilities not directly affecting their service-connected ills.

An additional 25 percent were permanently and totally disabled and were receiving VA pensions for such disabilities. This adds up to a total of 71 percent. A total of 2 percent were admitted for strictly emergency and humanitarian causes with their veteran status not determined.

Admiral Boone adds that "patients are admitted after examination and determination by qualified physicians that they are in need of hospitalization." He says that to challenge the validity of admission of these patients "comes near to charging charlatanism on the part of doctors."

He stated that "the military services themselves were guilty of waste in the last war when more doctors than needed were drafted and kept in camps or in the field without doing medical work."

Dr. Harold Hillenbrand, secretary of the American Dental Association also labelled the charges untrue and undeserved.

Dr. Pugh afterward softened his attack by saying that he meant no blanket indictment of his profession but that his target was the minority element that hides its distaste for service behind the subterfuge that military medicine is not made attractive enough in a professional way.

AMA, Dental Leaders Blast Back at Pugh

Chicago, November 17.—AMA headquarters lost no time in blasting back at Rear Admiral Lamont Pugh, surgeon general of the navy, when he told the annual meeting of the Association of Military Surgeons in Washington that "big money" in civilian practice is keeping many physicians and dentists from entering military service.

"The fact of the matter is that most physicians, like most civilians, prefer a non-military life," the AMA said. "This is especially true in peacetime. When patriotism is at stake, the doctor, like everyone else, is always ready to serve his country. During World War II more than 60,000 physicians served in the armed forces and they all served voluntarily."

AMA president Dr. Louis H. Bauer personally took the floor at the military surgeons' meeting to label Pugh's statement "an unjustifiable slur on the vast majority of the medical profession."

OSCAR GOES ON FAREWELL JUNKET

Washington, Nov. 17.—FSA Administrator Oscar Ewing is getting a farewell trip at public expense to attend two international conferences in India and do a bit of junketing in European capitals next month, swapping ideas on social welfare.

Ewing recently assembled his whole staff to listen to an address by Sir George Henry Henderson, secretary of Scotland's department of health, on practices and experiences under Britian's socialized system of health care.

FORMS COMMISSION . . .

(Continued from page 1233)

school health. These defects are often of great consequence to the Motor Vehicle Department, and the new commission might be consulted by them.

The establishment of this commission, consequently, is intended to streamline and correlate committee work within the society. At the same time it should be of benefit to the public because, according to Dr. Arveson, "Medical advice to all departments should be closely coordinated for more uniform application of sound medical practices and more effective service to the people who receive health services from one or more state departments."

The commission will be available to any state department seeking professional guidance in carrying out its program.

COURT OF APPEALS LABELS HOXSEY CANCER CURES FALSE, ISSUES BAN

Washington, D. C., Oct. 25.—Claims that the Hoxsey liquid medicines are effective as a "cancer cure" have been called "false and misleading" by the U.S. Court of Appeals.

The decision reverses the judgment of a U.S. District Court at Dallas, Texas, and orders that court to issue an injunction prohibiting the Hoxsey Cancer Clinic and Harry M. Hoxsey from distributing in interstate commerce the brownish black and pink liquids intended for the treatment of cancer.

In many parts of the country, people are taking the Hoxsey medicines in the belief that they may be an effective treatment for cancer, according to C. W. Crawford, commissioner of foods and drugs in the Food and Drug Administration. He pointed out that friends and relatives of cancer victims frequently ask local physicians about this treatment.

Gives Herbal Medicine

Hoxsey's patients came to his Dallas Clinic from practically every state in the country. Patients were examined at the rate of 35 to 50 per day and the usual fee was $400 per patient. The medicines were composed chiefly of a laxative and potassium iodide with extracts of prickly ash, red clover blossom and alfalfa. One remedy was flavored with elixir of lactated pepsin to disguise the unpleasant taste of potassium iodide.

Based on testimony by cancer experts, the Circuit Court opinion laid down the following important principles:

1. **"***there is only one reliable and accurate means of determining whether what is thought to be cancer is, in truth and fact, actually cancer. This requires a biopsy, a microscopic examination of a piece of tissue removed from the infected and diseased region."**
2. **"***the opinion of a layman as to whether he has, or had, cancer, or a like opinion as to whether he has been cured and no longer bears the disease, if, in fact, it ever actually existed, is entitled to little, if any, weight."**
3. **"***despite the vast and continous research which has been conducted into the cause of, and possible cure for, cancer the aggregate of medical experience and qualified experts recognize in the treatment of internal cancer only the methods of surgery, X-ray, radium and some of the radio-active by-products of atomic bomb production."**
4. **"***upon such subjects a court should not be so blind and deaf as to fail to see, hear and understand the import and effect of such matters of general public knowledge and acceptance, especially where they are established by the overwhelming weight of disinterested. * * *"**

According to the unanimous opinion of the Court of Appeals, 'the overwhelming weight of the credible evidence requires a conclusion that the representation that the Hoxsey liquid medicines were efficacious in the cure of cancer is . . . false and misleading. The evidence as a whole does not support the finding of the trial court that 'some of it cures, and some of it does not cure, and some of it relieves somewhat.'"

MISS MARGARET WAALA

WAUTOMA GIRL WINS SMS HEALTH AWARD

Miss Margaret Waala, Wautoma, of the Mt. Morris Pioneers 4H Club, Waushara county was the State Medical Society's choice as winner of its annual scholarship trip to the National 4H Club Congress in Chicago early this month.

Miss Waala was sent to Chicago on a $100 scholarship provided by the society. This grant is made each year under supervision of the society's Council on Med.cal Service as a part of their program to stimulate better health practices in communities by means of 4H work.

Miss Waala first became interested in the "Good School Lunch" item of the 4H program and for the past four years has been health committee chairman of her group. Planning the year's program is her responsibility, and she has plugged such subjects as good posture, safety, vitamins and first aid. She has attended the Bayfield Health Camp as Waushara county's representative.

CLAIM BLANKS

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REGIONAL RURAL HEALTH CONFERENCES ARE HELD

Madison, November 20.—Doctors are gradually becoming more public health conscious. Even so, they often allow their concern for their own patients to keep them from giving enough time to public health considerations, particularly those of rural health.

This was an opinion expressed by **Dr. R. L. MacCornack**, chairman of the State Medical Society's rural health program to those attending the regional conferences.

Under Dr. MacCornack's direction, a new approach to the rural health meeting was tried this fall. Instead of one large meeting, four smaller regional conferences were held, one each in Green Bay, Madison, Wausau and Eau Claire. It was hoped that elimination of the travel time necessary to reach one central point would encourage greater attendance.

The regional conferences were one-day affairs and were set up under similar plans. Each one started with a panel discussion of water sanitation and the Grade A milk program. **Dr. R. A. Nichols** of the University of Wisconsin's department of veterinary science was panel chairman at the Green Bay conference, and at the other three the morning program was headed by **Dr. W. D. Stovall** of the State Laboratory of Hygiene, Madison.

T. A. Calabresa, head of the well drilling division of the State Board of Health, was present at all four meetings to explain the new well drilling code adopted in 1951.

Dr. Stovall emphasized the great importance of sanitary water supplies to the health of every farm family as well as to the public that consumes the milk the farm produces. He stated that 50 percent of farm water supplies in the state are polluted, but said that there had been much correction since the adoption of the new code.

At all of these meetings, farmers wives expressed concern regarding the number of rural people who do not make proper use of their own products and who drink unpasteurized milk.

At each of the conferences, luncheon was followed by a talk on the subject of preventing accidents to young children given by a pediatrician. *Dr. E. Madison Paine* of Green Bay spoke at the meeting there. In Madison the subject was treated by *Dr. John R. Schroder* of Janesville, and *Dr. H. Kent Tenney III*, Madison, spoke at the luncheons in Wausau and Eau Claire.

DR. R. L. MACCORNACK

The afternoon programs featured three workshops running concurrently. Those on immunization were headed by **Dr. G. B. Merline**, Green Bay; **Dr. C. E. Hopkins**, Madison; **Dr. E. P. Ludwig**, Wausau and **Dr. Robert M. Lotz**, Eau Claire in their respective towns.

At each meeting Ralph Kuhli of the State Board of Health was on hand to conduct the discussions on home safety. "Bringing Health Department Services to the Farm" was headed in Green Bay and Wausau by **Dr. G. M. Shinners**, Green Bay; in Madison by **Dr. M. W. Stuessy**, Brodhead and in Eau Claire by **Dr. Rex Graber** of the Chippewa Falls health department.

Mr. Kuhli's panels on safety all hammered at the fact that carelessness is what causes accidents and that there must be an unceasing educational campaign—not an occasional promotion—to keep accident prevention in people's minds.

The problem of bringing health department services to the farm brought out a wide variety of discussion. Basic premises reached at all the meetings were.

1. There must be a recognition by rural people of their public health needs before they are ready to tax themselves to provide for them.

2. Every possible method of education should be used to create this recognition, and doctors and other health leaders must be aggressive in their dealings with lay people since they are the technicians who must "sell" their techniques.

3. Every county should have a health council or health department, and counties too poor to afford health services on their own should attempt to combine with other neighboring counties in a joint effort.

HEALTH LEADERS AND FARM PEOPLE sit down together at the Rural Health Conferences to discuss their mutual problems. Photographed at the Madison conference were, left to right, Miss Emily Strelch, public health nurse assistant, Sparta; Mrs. Ben Zimmerli, farmer's wife, Route 2, Brodhead; Mrs. Bernard LaRue, farmer's wife, Ironton and George Dehnert, assistant county agent of Dane county. Photo courtesy of the Prairie Farmer.

DISCUSSION LEADERS OF MILK AND WATER SANITATION PANEL were snapped at the Wausau regional Public Health Conference in November. Shown left to right are T. A. Calabresa of the well drilling division, State Board of Health; L. F. Bugbee, city health officer of Wausau; C. K. Luchterhand, board of health milk sanitarian, Madison; Dr. W. D. Stovall, state laboratory of hygiene, Madison, who served as chairman; Kenneth Wedin, county agent, Merrill; Herbert Lonsdorf, Marathon county sanitarian, Wausau and W. H. Doyle, district sanitary engineer, Wausau. Photo by Franklin E. Bump, Jr., Wausau.

The difference between a health council and a health department was carefully defined. A council is a group of lay people, perhaps with some professional membership, which finds out the facts concerning the health services available, decides what is needed in addition, and then follows through to see that the necessary services are provided for all.

A health department, on the other hand, is an official agency consisting of a medical health officer, public health nurses, a sanitary engineer or sanitarian and necessary clerical help.

Great hopes are held for the educational possibilities along public health lines which may be offered by television in the future.

Each of the regional meetings had as its finale a safety film significantly entitled "Hands Off" which dealt with corn-picker accidents.

Dr. MacCornack was present at each of the regional meetings to preside at the general sessions and take part in the panels on safety. It is his feeling that locating meetings according to region brought out more local health leaders than might have been expected at a central meeting.

Hill–Burton Hospital Construction Program Seen Slowing Down

Washington, Nov. 4.—During the past six years, the Hill–Burton Hospital Construction program has approved 1,877 projects for federal grants totaling just over half a billion dollars. Of the 90,645 beds involved, about 44 per cent are now in operation and the remaining are in planning stages or under construction.

The latest progress report as of September 30 also shows that inflation and budget restrictions are rapidly slowing down the program. In the fiscal year of 1950, a total of 537 projects were completed or on the books. The total for the current year is not expected to exceed 150. Since 1949, construction costs per bed have increased about 50 percent.

The program was designed primarily for the building of small hospitals in rural areas, but from the start a high percentage of funds has gone instead to relatively larger institutions in urban areas. Determination of what projects to assist rests with state hospital authorities since, under the law, funds are allocated to the states for distribution.

Claims MDs Drafted to Care for Civilians

Washington, Nov. 20.—Dr. Louis H. Bauer, president of AMA, says many doctors hesitate to volunteer for military service because they feel too much of their time is wasted treating wives and children of armed forces members.

Said Dr. Bauer, "Questionnaires sent to medical men on leaving the services cite this frequently as a cause of resentment—namely that they have been drafted from civilian life to take care of other civilians."

He stated that the medical services of the armed forces are still suffering from unfavorable reactions resulting from the last war. "There is no doubt," he says, "that doctors were wasted at that time. Many were kept weeks and months in mobilization camps doing little. Others were assigned to duties of a nonmedical nature . . . Many, in fact most, of these conditions have now been largely eliminated . . . Unfortunately, this is not widely known."

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ARMY SEEKS TO CLARIFY BASIS FOR DEFERMENT OF MD HARDSHIP CASES

Madison, Nov. 25.—Many army, air force and navy physicians in the reserves who face recall to active duty have sought information on how to obtain deferment when business or family situations present problems of personal hardship.

For all non-medical reservists, a status of four or more dependents is considered a sufficient basis to delay recall for an idenfinite period. This is because the supply of young officers is practically equal to the demand, due to volunteer sources such as officer candidate schools, R.O.T.C. and military academies.

Since medical personnel is in much shorter supply, a different yardstick must be applied and deferments cannot be granted on the basis of number of dependents alone.

A letter from the office of the commanding general, Fifth Army headquarters, written November 10, 1952 attempts to clarify the hardship situation among doctors and dentists as follows:

"An undue hardship must be proven to allow favorable consideration, whether it be for one or six dependents. Undue hardship is considered to exist when the officer or his family will endure real and unwarranted suffering as a result of active military service, greater than the normal hardships which are being experienced by members or families of members of the military service of similar military status.

"Undue hardship will not be considered to necessarily exist solely because of altered present or expected income, or because the individual is separated from his family, or must suffer the inconveniences normally incident to military service.

"Indebtedness does not preclude a call to active military service in view of appropriate moratoriums available to those entering military service, under the Soldiers and Sailors Relief Act, as amended. A request for delay or exemption for undue hardship, accompanied when in your judgment corroboration appears indicated, by letters, affidavits, or other documentary evidence (exclude birth certificates) to clearly establish the following:

1. That the undue hardship does or undoubtedly will exist.
2. That the hardship is of a temporary or permanent nature.
3. That there are no means of alleviating the condition other than by delaying or exempting the officer from active military service.

"Many physicians and dentists with four or five dependents are in service. . .

"Where hardship was based on separation of family, appropriate recommendations have been made to the Surgeon General who has assignment responsibilities, to consider station assignments in the continental United States where an officer may eventually have his family join him, thereby minimizing the hardship from this source."

The letter concludes that when a special registrant is "ordered for induction" it is assumed that every possible consideration has been given his case.

Charge Armed Forces with "Freezing" Doctors

Washington, D. C., Aug. 18.—A sizeable number of young physicians who signed up for Army and Navy residencies in civilian hospitals in 1948 and 1949, and who were sent to Korea soon after the outbreak of war there, have been frozen in uniform and cannot get out even though they have fulfilled their periods of obligated service.

To get their residencies these physicians were required to agree to serve their active duty as Regulars, and resignations of Regulars are not being approved today because of the emergency. The majority of these physicians feel Uncle Sam's end of the bargain should be kept. Army–Navy medical personnel officials acknowledge they have a case and are genuinely concerned over the injurious effect this situation will have on the recruitment of the Regular corps.

They point out, however, that if these young doctors had not taken the residencies with full pay and allowances, they would have been brought into uniform a year or two later anyway under the provisions of the doctor–draft law.

WSES Tells of Openings for MDs

Madison, Nov. 20.—During the past few months the Wisconsin State Employment Service has received a number of requests for doctors, who are needed both within and outside of the state.

There is currently an opening for a District Health Officer located in District 1, with headquarters in Madison, and another in District 9 with headquarters in Ashland. There is also an opening for a physician who will take charge of the tuberculosis control and heart programs within the State Board of Health set-up in Madison.

Currently positions are open for three medical men in Washington, D. C. One opening for a staff physician pays $7,040 to start and the employing hospital is willing to consider an applicant who has just finished his internship. The other two openings are for M. D.'s who have had psychiatric and administrative experience. The annual salaries on the latter two jobs are $9,600 and $8,360 respectively.

Society members are asked to refer physicians, members of other professions, technicians and others known to be seeking employment to the nearest WSES office.

MEDICAL TABLOID ADDS TO EXHIBIT

Springfield, O., Nov. 10.—The Clark County, Ohio, Medical Society decided it would sponsor a booth at the county fair this election year. Its public relations committee, in charge of the exhibit, did not want to pass out "canned" literature. Instead they put out a 4-page tabloid size newspaper called "The Clark County Medical News."

This attractive newspaper carried stories on such subjects as the society's health exhibit at the fair, the society's emergency call service system, the cost of medical care, family physicians, the film "Your Doctor," and doctors' community service activities. The third page was devoted to a montage of pictures and stories about medical subjects which had appeared in a local newspaper.

Five thousand copies of the newspaper were distributed to fair-goers.

PATHOS STORIES OFTEN PUT DOCTORS ON THE SPOT

Chester, Pa., Nov. 20.—Pathetic stories about unique medical cases and incurable ailments make fine "human interest" features for newspapers. Often the public is roused by these tales of woe to start a community fund for the stricken family.

Nobody can blame the reporters in these cases for following up a "natural" story. But to the public it implies that medical care is out of the reach of the families affected because of its high price tag.

A recent story about a nine-month old baby was headlined in Chester, Pennsylvania: "Parents Need $1,000 to Save Baby's Sight." The caption over a picture of the baby and his mother read: "An Operation Could Give Him Sight."

The Delaware County Medical Society at once went into action, publishing the fact that there were facilities in the Delaware County hospitals for the care of such needy cases upon request. They emphasized that doctors provide much free care and that, in this case, medical aid was available but was not requested.

What can your medical society do to forestall such damaging stories? Here are some suggestions quoted from the AMA public relations bulletin.

1. Impress upon society members the PR dangers of such stories.
2. Gain their unanimous consent to provide free medical services should such cases arise.
3. Set up a society committee to deal with such cases quickly.
4. Survey local health and welfare groups and hospitals to determine what aid is available.
5. Personally inform newspapers and radio stations that medical aid is available and ask them to contact the society immediately about such stories.
6. Contact your state society to learn what other county societies are doing to solve similar problems and to coordinate your efforts.
7. Make known and stand behind your guarantee of "medical care for all."
8. Send out actual stories to the press from time to time on interesting cases which were treated free, if the stories can be released without damaging the doctor-patient relationship.

Then when the next "tear-jerking" story appears in your community, its first newspaper headline may read: "Doctors to Help Blind Baby See."

Hold 2-Day PR Session for Toledo Physicians

Toledo, O., Nov. 20.—Pioneering in public relations, Toledo doctors last month held what probably was the first two-day post-graduate course devoted to doctor-patient relationships.

The lectures were given by Ernest Dichter, Ph.D., author of the now famous California report on doctor-patient relationships. He pointed out that what amounts to a "cultural lag" has developed in this field, saying that our culture is changing and doctors must change their ways to keep pace.

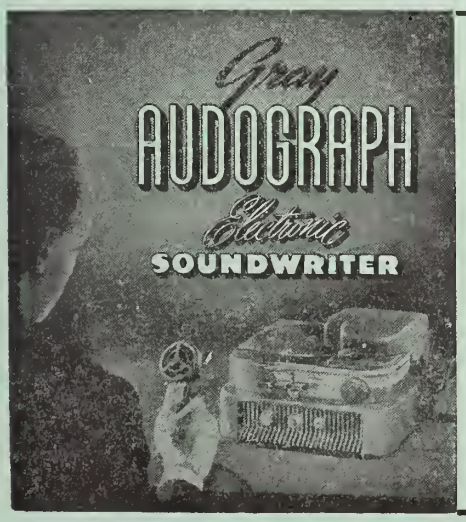
Among the questions discussed by Dr. Dichter were "How can I make my patients like me better from a professional viewpoint?", "How can I avoid the appearance of being rushed?" and "How can I arrive at a proper fee without antagonizing patients?"

Want an Exhibit? Get Directory from the State Office

Chicago, Oct. 22.—The A.M.A. Bureau of Exhibits is now distributing a new, attractive 10-by-7-inch pamphlet showing 25 different health exhibits that are available from the A.M.A. for showing at fairs and expositions throughout the United States.

The pamphlet carries a large illustration of each exhibit, along with a brief description and such installation data as the minimum space required, the electrical requirements and the approximate shipping weight. It also carries an order blank, which can be torn out of the pamphlet and mailed to the A.M.A.

Pamphlets may be obtained by physicians from the state medical society office.



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REPUBLICAN ADMINISTRATION AGREES WITH AMA ON MAJOR MEDICAL ISSUES

Washington, Nov. 12.—The Republican administration should be found in fairly close agreement with the American Medical Association on several major medical issues due to reappear before Congress in the next two years—issues on which the AMA and the Democratic administrations have been continuously at odds.

According to a recent AMA bulletin, the Republican platform and pre-election statements by General Eisenhower suggest that the following situation may be expected:

Socialized medicine: General Eisenhower has stated repeatedly that he is opposed to national compulsory health insurance or socialization in any other form. On this he is supported all the way by the Republican party platform. In contrast, President Truman consistently advocated compulsory health insurance.

Aid to medical education: General Eisenhower is determined that every effort be made to support medical education without resort to federal financial assistance. AMA is in agreement with his ideas, believing that states and private sources should be responsible for supporting schools, with federal funds used only for "one time" construction and equipment grants where the need is clearly demonstrated.

Pension plans for self-employed: The General has indorsed extension of tax relief to self-employed persons to help them establish pension funds, a proposal which has the active support of AMA.

Veterans medical care: The General has promised a "firm assessment" of the VA's medical care program, stating that charges of deterioration are "seriously disturbing" to him. He added "I shall exert every effort to achieve a Veterans Administration program for proper maintenance of its many services and benefits, including the best medical care and facilities available."

Research and hospitals: The Republicans have pledged continued support of scientific research, the encouragement of improved methods of assuring health protection and the maintenance of a program to stimulate development of adequate hospital services.

Social Security: General Eisenhower has stated "We must improve and extend Social Security . . . Security for old age, unemployment insurance and care for dependent children and widows are moral obligations."

Ask 30-Day Supply Limit on Drugs for Veterans

Milwaukee, Dec. 1.—The VA regional office in Milwaukee has issued a request that prescriptions for medication for veterans be limited to a 30-day supply, especially if it is to be filled by a local pharmacy.

Recently there have been several instances where physicians have prescribed to provide a supply of medicine for anywhere from 60 to 100 days. Dr. S. E. Sebastian, chief medical officer in Milwaukee, says that prescribing for only 30 days will give the regional office an opportunity to supply the remaining portion of the needed drugs from their own pharmacy.

Deadline Is Near for Bookings of Film "Your Doctor"

January 1, 1953 is the deadline for booking the film "Your Doctor" into local theaters.

After that date, this picture will be made available in 16 mm version to film libraries for showing to schools, clubs and other special interest groups.

Since movie houses attract a cross-section of community residents, theater booking will pay the biggest public relations dividends.

To arrange a booking, have a representative of your county society or its auxiliary call or visit the theater manager. Tell him the medical profession is interested in having "Your Doctor" shown on one of his regular programs, and offer society cooperation in publicizing it. When the booking is set, use all your society's facilities to help build an audience.

Theater managers secure "Your Doctor" from the RKO Pictures distribution office in the area.

Believe Set to Introduce Compulsory Health Bill

Washington, D. C., Sept. 22—There is more than appears on the surface to the political campaign talk about compulsory health insurance.

"I expect to introduce a health program bill in the next Congress," Congressman Dingell, Democrat, Michigan is reported to have said. "I assume it will be similar to the bill I introduced in January 1951, but I don't want to go into details just yet."

Rep. Dingell has more recently been quoted as being uncertain whether he will reintroduce his compulsory health insurance bill in 1953, according to the Washington Report on the Medical Sciences.

Mr. Dingell, it will be recalled, was co-sponsor of the series of Wagner–Murray–Dingell bills methodically pigeonholed in earlier Congresses.

After Senator Wagner's departure from the Senate, Dingell and Murray carried on.

Reportedly, the Social Security Administration plans to make appropriate changes in the last year's bill and offer it to Murray and Dingell for introduction in the 83rd Congress.

It is intended that it will cover fully the National Health Insurance program with possible alterations to meet chief objections voiced against the program in the past.

Hope is that the bill can be introduced without a tax provision in order to have the bill referred to the Committee on Interstate Commerce whose jurisdiction covers Health legislation and which in the past has been more friendly than the Ways and Means Committee which must handle all tax legislation. Cost of the new program would approximate 4 billion dollars a year.

This would be met by an assessment of 3% on payrolls up to $4,800 a year of individual earnings.

through private insurance carriers had been sufficiently extensive in Price–Taylor as to indicate that the experimental plan be terminated, and that no further program be introduced for that area.

Information has been received from physicians in the Sixth District respecting the closing of two nursing schools in Green Bay, and protesting the action. Permission was requested by the secretary to participate in a hearing on this matter which has been scheduled by the State Department of Nursing on December 3. It is contemplated that a staff member will be assigned to attend the hearing and report back to the Council at a later date with respect to the problems involved.

On motion of Doctors Ekblad–Kidder, carried, the Council approved State Medical Society representation at the December 3 hearing.

On motion of Doctors McCarey–Bell, carried, the proper committee within the Society was instructed to study the problem and to report back to the Council.

8. State Laboratory of Hygiene

On Saturday, February 21, 1953, the new State Laboratory of Hygiene, under the directorship of Dr. W. D. Stovall, will be dedicated at the University of Wisconsin in Madison. The new laboratory results from the planning of Doctor Stovall and marks a milestone in public health efforts. It will be of service to the entire state in the application of science to the control of disease through a centralized facility.

The Interim Committee of the Council has discussed the event with a view to determining how the State Medical Society could participate in the ceremonies, and recommends to the Council that its February meeting be held the morning and early afternoon of February 21. Dedication ceremonies at the laboratory will be held at 3:00 p.m., and it is suggested that the State Medical Society sponsor a testimonial dinner that evening to which would be invited prominent people in the health movement in the state, including the governor, legislators, the Board of Regents, and the Board of Health. Probably 100 to 125 people would attend.

The Interim Committee recommends that the secretary's office plan the evening event and that it be authorized to expend up to $1,000, the exact cost dependent on how many would attend.

On motion of Doctors Dessloch–Bernhart, carried, the Interim Committee recommendation was approved and the secretary instructed to proceed with planning the event.

9. Suspension of By-Law re Time Limits for Speakers

It is the opinion of the Council on Scientific Work that the section of the By-Laws respecting time limits for speakers on scientific programs is obsolete and needs revision. As the rule now reads, it would not permit the Council to grant to a Wisconsin speaker more than 20 minutes, regardless of whether the appearance is on the general program or section programs.

Because action of the House of Delegates is necessary to change a By-Law (except in emergency) it is recommended that the Council suspend this By-Law for the 1953 Annual Meeting and authorize the Council on Scientific Work to use its discretion in determining time limits for all speakers.

On motion of Doctors Kasten–Ekblad, carried, the Council approved elimination of the By-Law requirement for the 1953 Annual Meeting.

Prior to the 1953 meeting the Council will consider formal recommendation to the House of Delegates to amend the By-Law.

10. Change of Annual Meeting Dates

A. Dates of 1953 and 1954 Annual Meetings—It is the opinion of the Council on Scientific Work that greater attendance of members may be stimulated by having the scientific sessions held on Tuesday, Wednesday, and Thursday. This is based on the experience of other states, and the fact that many physicians normally close their offices on the afternoons of either Wednesday or Thursday.

It is further recommended that conflicting events be scheduled so as not to overlap with the scientific sessions, whenever possible. It is specifically suggested that the golf tournament be scheduled for Monday afternoon, rather than on the afternoon of the final day of scientific meetings. (In order to integrate the planning, the staff of the State Medical Society is perfectly willing to accept responsibility, if it is offered them, to serve those interested in the golf tournament in planning details.)

It is not within the jurisdiction of the Council on Scientific Work to suggest the scheduling of meetings of the House of Delegates. While the Council would like to see a schedule prepared which would not overlap meetings of the House of Delegates with scientific sessions, it is recognized that if opportunities are to be provided members (other than delegates) to appear before reference committees such a complete separation is not practical.

If the scientific sessions would be held on Tuesday, Wednesday and Thursday, the following schedule for other functions might be as follows:

Council: Sunday night and Monday morning.
House: Monday afternoon, or Monday evening, Tuesday evening, Wednesday morning.
Golf Tournament: Monday afternoon and evening.

On motion of Doctors Ekblad–Hill, carried, the recommendation of the Council on Scientific Work that the scientific sessions in 1953 be held on Tuesday, Wednesday, and Thursday, October 6, 7, and 8, was approved.

B. Dates for Annual Meetings Starting with 1955—It is increasingly apparent that the fall months offer many difficulties for the successful operation of an Annual Meeting, and the Council on Scientific Work has considered the advisability of changing the date. Originally, the present dates of

early October were chosen to complete a logical circuit with the states of Michigan and Indiana, as a convenience to exhibitors. Since then, on several occasions, the Michigan meeting time has been shifted, so this arrangement is no longer an important factor in determining the dates for the Wisconsin meeting. In view of the fact that several large national meetings are scheduled close to the first week in October, it has been suggested by some members that a late spring date would be more desirable.

Consultation with the Milwaukee Association of Commerce indicates that if a shift in dates is to be made, the earliest this could be accomplished would be 1955, and it has been suggested that the last week in April or the first week in May could be arranged. If this were done, it could be scheduled so as to precede the Minnesota meeting by about two weeks, and follow the Ohio meeting by about 10 days, which might be desirable from the viewpoint of securing exhibitors who wish to cover meetings in the same region on a consecutive basis.

It would not seem desirable to schedule a meeting in the spring later than May 15, as this would be so close to the June meeting of the American Medical Association that it might affect attendance in those years when the AMA meeting is held in Chicago.

On motion of Doctors Wegmann–Bernhart, carried, the secretary was granted authority to tentatively tie up dates in late April or early May of 1955, which would then become the regularly scheduled dates of subsequent meetings of the State Medical Society.

11. Fort Crawford Military Hospital

President Griffith, on behalf of the Interim Committee, reported the proposal it has had under consideration that the State Medical Society establish a medical museum in the restored hospital building at Second Fort Crawford, Prairie du Chien.

The Society has been in consultation with the State Historical Society respecting the proposal, which recommends that if the Society took over the building it be devoted to the presentation of general medical and surgical history. A general museum should have considerable popular interest, which in turn would mean larger revenues from admission fees and a better chance of ultimately attaining self-sufficiency.

The State Historical Society further recommends that such a museum should be owned by the State Medical Society and operated by the Historical Society by agreement with the owner, and that such an agreement be initiated for action by the respective Council and Board of the two societies.

It was suggested to the Council by the secretary that a special voluntary membership classification of the State Medical Society might be established which would supervise and direct this program. Funds for this purpose, accumulated through dues or gifts, could be under direction of such a group.

On motion of Doctors Dessloch–Hill, the secretary was instructed to develop a plan for later Council consideration under which the proposal could be supervised and carried out.

12. AMA Clinical Session

By prior action of the Council, it considers matters to be presented to the House of Delegates of the American Medical Association previous to its meetings so that expressions of opinion may be offered Wisconsin AMA delegates.

The secretary advised the Council and delegates that he was informed a statement would be presented at the AMA midyear meeting in Denver, December 2–5, with reference to the Veterans Administration and the operation of its hospitals.

Mr. Crownhart further reported that at the North Central Medical Conference held in Minneapolis in November, a discussion of veterans' medical care brought out opposition to the resolution of the Tennessee State Medical Association, which is now being considered by a committee of the AMA. The Tennessee resolution, among other things, advocates the setting up of a standard medical and hospital insurance policy, at government expense, for veterans unable to pay the premium costs of such a policy. By formal action at the Conference, the AMA delegates of the six states represented were instructed to oppose the resolution at the December meeting in Denver.

13. Adjournment

The meeting was adjourned at 12:20 p.m., Sunday, November 23, 1952.

C. H. Crownhart
Secretary

Approved:
R. G. Arveson, M.D.
Chairman of the Council

UNIVERSITY OF MINNESOTA ANNOUNCES POSTGRADUATE COURSE

A one-day continuation course in Management of the Polio Patient will be presented at the Center for Continuation Study on the University of Minnesota Campus on January 15, 1953. The recent epidemic of poliomyelitis has brought out the need of a course dealing with this disease. Management of all phases of the disease will be discussed, but emphasis will be placed on the care of the convalescent patient.

Attendance at House of Delegates, Milwaukee
October 5, 6, 7, 1952

Society	*Delegate*	*Sessions* 1	2	3
Ashland–Bayfield–Iron	J. W. Prentice, Ashland	a	a	x
	J. E. Kreher, Ashland*	a	a	a
Barron–Washburn–Sawyer–Burnett	N. A. Eidsmoe, Rice Lake	a	x	x
	C. J. Strang, Barron*	a	a	a
Brown–Kewaunee–Door	J. W. Nellen, Green Bay	x	x	x
	P. F. Dockry, De Pere*	a	a	a
	J. A. Killins, Green Bay	x	x	x
	R. M. Waldkirch, Green Bay*	a	a	a
Calumet	E. W. Humke, Chilton	x	x	x
	A. C. Engel, New Holstein*	a	a	a
Chippewa	W. C. Henske, Chippewa Falls	x	x	x
	J. J. Sazama, Chippewa Falls*	a	a	a
Clark	M. V. Overman, Neillsville	a	a	a
	H. H. Christofferson, Colby*	x	x	x
Columbia–Marquette–Adams	J. H. Houghton, Wisconsin Dells	x	x	x
	H. A. Winkler, Pardeeville*	a	a	a
Crawford	T. F. Farrell, Prairie du Chien	x	x	x
	H. E. Oppert, Gays Mills*	a	a	a
Dane	T. A. Leonard, Madison	x	x	x
	N. A. Hill, Madison*	a	x	x
	A. T. Smedal, Stoughton	x	x	x
	H. L. Greene, Madison*	a	a	a
	T. W. Tormey, Jr., Madison	a	x	x
	R. N. Allin, Madison*	a	x	x
	O. O. Meyer, Madison	x	x	a
	J. A. Grab, Sun Prairie*	a	a	a
	J. A. Hurlbut, Madison	x	x	x
	L. E. Holmgren, Madison*	a	a	a
	A. A. Quisling, Madison	x	x	x
	W. A. Tanner, Madison*	a	a	a
Dodge	A. B. Kores, Beaver Dam	x	a	a
	L. W. Schrank, Waupun*	x	x	x
Douglas	Charles W. Giesen, Superior	x	x	x
	H. B. Christianson, Superior*	a	a	a
Eau Claire–Dunn–Pepin	Oscar Moland, Augusta	x	x	x
	R. J. Bryant, Eau Claire*	a	a	a
Fond du Lac	D. J. Twohig, Sr., Fond du Lac	a	a	x
	H. J. Kief, Fond du Lac*	x	x	x
Forest	E. F. Castaldo, Leona	x	x	x
Grant	B. S. Rathert, Crandon*	a	a	a
	K. L. Bauman, Lancaster	a	x	x
Green	J. W. Conklin, Platteville*	x	a	a
	M. W. Stuessy, Brodhead	x	x	x
Green Lake–Waushara	L. G. Kindschi, Monroe*	a	a	a
	D. P. Cupery, Markesan	x	x	a
Iowa	L. S. Shemanski, Wautoma*	a	a	a
	C. L. White, Mineral Point	a	a	a
Jefferson	S. C. Jackson, Dodgeville*	a	a	a
	C. J. Garding, Jefferson	x	x	x
Juneau	F. A. Gruesen, Fort Atkinson*	a	a	a
	J. H. Vedner, Mauston	x	x	x
Kenosha	V. M. Griffin, Mauston*	a	a	a
	D. N. Goldstein, Kenosha	x	x	x
La Crosse	L. H. Lokvam, Kenosha*	a	a	a
	T. E. Gundersen, La Crosse	x	x	x
Lafayette	D. M. Buchman, La Crosse*	a	a	a
	L. J. Unterholzner, Blanchardville	x	a	a
Langlade	D. J. Garland, Shullsburg*	a	x	x
	F. H. Garbisch, Antigo	a	x	a
Lincoln	C. E. Zellmer, Antigo*	x	a	a
	R. G. Baker, Tomahawk	a	x	a
Manitowoc	K. A. Morris, Merrill*	a	x	x
	E. C. Cary, Reedsville	x	x	x
Marathon	E. W. Huth, Valders*	a	a	a
	H. R. Fehland, Wausau	x	x	a
Marinette–Florence	E. P. Ludwig, Wausau*	a	a	x
	C. E. Koepp, Marinette	x	x	x
Milwaukee	K. G. Pinegar, Marinette*	a	a	a
	A. J. Baumann, Milwaukee	x	x	a
	R. A. Frisch, Milwaukee*	a	a	x
	J. B. Wilets, Milwaukee	x	x	x
	C. W. Harper, Milwaukee*	a	a	a
	R. F. Purtell, Milwaukee	x	x	x
	P. E. Oberbreckling, Milwaukee*	x	a	x
	J. A. Enright, Milwaukee	x	x	x
	C. F. McDonald, Milwaukee*	a	x	a
	P. J. Niland, Milwaukee	x	a	x
	A. D. Kilian, Milwaukee*	a	a	a
	W. T. Casper, Milwaukee	x	x	x
	L. A. Weisfeldt, Milwaukee*	a	a	a
	T. J. Aylward, Milwaukee	x	x	x
	Donald M. Willson, Milwaukee*	a	a	a
	D. F. Pierce, Hales Corners	a	a	a
	E. A. Habeck, Milwaukee*	a	a	a
	S. A. Morton, Milwaukee	a	a	a
	H. E. Bardenwerper, Milwaukee*	x	x	x
	J. D. Charles, Milwaukee	a	x	a
	I. J. Ricciardi, Milwaukee*	a	a	a
	E. R. Daniels, Milwaukee	x	x	a
	E. P. Bickler, Milwaukee*	a	a	x

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA

Society	Delegate	Sessions 1	2	3
	F. E. Drew, Milwaukee	x	x	x
	J. E. Conley, Milwaukee*	a	a	a
	J. W. Fons, Milwaukee	x	x	x
	J. P. Conway, Milwaukee*	a	a	a
	J. G. Garland, Milwaukee	x	x	a
	M. C. F. Lindert, Milwaukee*	a	a	x
	J. V. Herzog, Milwaukee	x	x	x
	P. J. Purtell, Milwaukee*	a	a	a
	S. W. Hollenbeck, Milwaukee	x	a	x
	L. R. Schweiger, Milwaukee*	a	x	a
	W. J. Houghton, Milwaukee	x	a	x
	Joseph Shaiken, Milwaukee*	a	a	a
	G. S. Kilkenny, Milwaukee	x	x	x
	J. M. Sullivan, Milwaukee*	x	a	a
	L. P. Stamm, Milwaukee	x	x	x
	M. S. Fox, Milwaukee*	a	a	a
	C. A. H. Fortier, Milwaukee	x	x	a
	Richard Foregger, Milwaukee*	a	a	a
Monroe	J. S. Allen, Norwalk	x	x	a
	Harry Mannis, Sparta*	a	a	a
Oconto	R. J. Goggins, Oconto Falls	a	a	a
	H. A. Aageson, Oconto*	x	x	x
Oneida–Vilas	Marvin Wright, Rhinelander	x	x	x
	I. E. Schiek, Sr., Rhinelander*	a	a	a
Outagamie	G. W. Carlson, Appleton	x	x	x
	J. E. Gmeiner, Appleton*	a	a	a
Pierce–St. Croix	P. H. Gutzler, River Falls	x	x	x
	O. H. Epley, New Richmond*	a	a	a
Polk	L. O. Simenstad, Osceola	x	x	x
	V. C. Kremser, Amery*	a	a	a
Portage	A. G. Dunn, Stevens Point	x	x	x
	R. H. Slater, Stevens Point*	a	a	a
Price–Taylor	J. D. Leahy, Park Falls	x	x	x
	W. W. Meyer, Medford*	a	a	x
Racine	E. J. Schneller, Racine	x	x	x
	L. J. Kurten, Racine*	a	a	a
	G. J. Schulz, Union Grove	x	x	x
	R. J. Schacht, Racine*	a	x	x
Richland	D. H. Hinke, Richland Center	x	x	a
	R. E. Housner, Richland Center*	a	a	x
Rock	H. E. Kasten, Beloit	x	x	a
	V. S. Falk, Edgerton*	a	a	a
	E. W. Reinardy, Janesville	x	x	x
	K. L. Carter, Beloit*	a	a	a
Rusk	L. M. Lundmark, Ladysmith	a	a	a
	Woodruff Smith, Ladysmith*	x	x	x
Sauk	J. F. Moon, Baraboo	x	x	x
	J. J. Rouse, Reedsburg*	a	a	a
Shawano	D. S. Arvold, Shawano	x	x	a
	J. W. Christofferson, Shawano*	a	a	x
Sheboygan	P. B. Mason, Sheboygan	x	x	x
	F. A. Nause, Sheboygan*	x	x	x
Trempealeau–Jackson–Buffalo	C. O. Rogne, Ettrick	a	a	a
	B. C. Dockendorff, Arcadia*	a	a	a
	Elizabeth Comstock, Arcadia**	x	x	a
Vernon	R. S. Hirsch, Viroqua	x	x	x
	T. P. Froehlke, Hillsboro*	a	a	a
Walworth	E. D. Sorenson, Elkhorn	x	x	x
	E. D. Hudson, Lake Geneva*	a	a	a
Washington–Ozaukee	A. H. Barr, Port Washington	x	x	x
	E. C. Quackenbush, Hartford*	x	x	a
Waukesha	M. J. Werra, Waukesha	x	x	a
	P. E. Campbell, Waukesha*	a	a	a
Waupaca	A. M. Christofferson, Waupaca	x	x	a
	F. J. Pfeifer, New London*	a	a	a
	H. C. Schmallenberg, New London**	a	a	x
Winnebago	R. H. Bitter, Oshkosh	x	x	x
	G. R. Anderson, Neenah	x	x	x
	J. P. Canavan, Neenah*	x	x	x
Wood	R. E. Garrison, Wisconsin Rapids	a	a	a
	K. H. Doege, Marshfield*	x	x	x
Section on General Practice	G. E. Forkin, Menasha	x	x	x
	J. A. Grab, Sun Prairie*	a	a	a
Section on Internal Medicine	M. A. Hardgrove, Milwaukee	x	x	x
	R. N. Allin, Madison*	a	x	x
Section on Neurology and Psychiatry	O. C. Clark, Waukesha	x	x	a
	Harry Tabachnick, Milwaukee*	a	a	a
Section on Obstetrics and Gynecology	M. M. Hipke, Milwaukee	a	x	x
	L. T. Servis, Milwaukee*	a	a	a
Section on Ophthalmology and Otolaryngology	A. H. Pember, Janesville	x	x	x
	E. J. Zeiss, Appleton*	x	x	x
Section on Orthopedics	P. J. Collopy, Milwaukee	a	a	a
	J. E. Miller, Madison*	a	a	a
Section on Pathology	W. A. D. Anderson, Milwaukee	x	a	a
	R. S. Haukohl, Milwaukee*	a	x	x
Section on Pediatrics	K. B. McDonough, Madison	x	x	x
	K. J. Winters, Waukesha*	a	x	x
Section on Radiology	W. T. Clark, Janesville	x	x	x
	H. W. Hefke, Milwaukee*	a	a	a
Section on Surgery	J. M. Sullivan, Milwaukee	x	a	a
	L. W. Peterson, Shawano*	a	a	a

*Alternate delegate.
**Acting Delegate.

Transactions of the 1952 Regular Session, House of Delegates, State Medical Society of Wisconsin

FIRST SESSION

Sunday, October 5, 1952

The first session of the House of Delegates of the State Medical Society of Wisconsin, held at the Hotel Schroeder, Milwaukee, convened at 3:00 p.m., Dr. H. Kent Tenney, Speaker of the House, presiding.

TRIBUTE TO DR. BYRON HUGHES

Doctor Tenney, in calling the House of Delegates to order, made the following comments:

"As you all know, I am presiding at this session of the House of Delegates because of the very untimely death of Byron Hughes.

"I have been a member of the State Medical Society for a good many years, but it was not my privilege to know Doctor Hughes very long; however, in the few years I did know him I gained a tremendous respect for his professional ability and tremendous admiration for his breadth of vision in the responsibilities of his profesSon in the state toward those with mental illness.

"I also learned to like him very much as a personal friend. He was one of the nicest men anyone could ever know. I think we can say of Byron Hughes as was said of another great physician: Wisconsin can get along without men like Byron Hughes, but Wisconsin can never get ahead without men like Byron Hughes.

"So, as we start this session, which should rightly be Byron Hughes' first appearance as Speaker of the House, I wish you would join with me in a moment of silent tribute to him."

The audience arose and stood in silent tribute to Doctor Hughes.

REPORT OF COMMITTEE ON CREDENTIALS

The Committee on Credentials, composed of Drs. T. J. Aylward, chairman, Milwaukee; D. S. Arvold, Shawano; and J. S. Allen, Norwalk, verified the registration of 57 delegates and six alternate delegates entitled to vote at this session of the House of Delegates. In addition, 15 alternate delegates, 12 councilors, and six past presidents registered their attendance.

On motion of Doctor Aylward, seconded by Dr. E. C. Cary, Reedsville, carried, the attendance roll totaling 63 was accepted as the official roll of this session of the House, to stand for the entire session.

ANNOUNCEMENT OF REFERENCE COMMITTEES

Speaker Tenney announced the following appointments to Reference Committees:

Reference Committee on Reports of Officers: L. O. Simenstad, Osceola, chairman; J. W. Fons, Milwaukee; M. W. Stuessy, Brodhead; D. N. Goldstein, Kenosha; and P. B. Mason, Sheboygan.

Reference Committee on Reports of Committees: G. W. Carlson, Appleton, chairman; Marvin Wright, Rhinelander; E. R. Daniels, Milwaukee; A. T. Smedal, Stoughton; and K. H. Doege, Marshfield.

Reference Committee on Resolutions and Amendments to the Constitution and By-Laws: H. E. Kasten, Beloit, chairman; E. D. Sorenson, Elkhorn; T. W. Tormey, Jr., Madison; O. G. Moland, Augusta; and J. M. Sullivan, Milwaukee.

MINUTES OF THE 1951 SESSION APPROVED

On motion of Dr. J. W. Fons, Milwaukee, seconded by Dr. M. W. Stuessy, Brodhead, carried, minutes of the 1951 regular session of the House of Delegates, as printed in the December 1951 issue of the *Wisconsin Medical Journal* were approved.

STANDING RULES ADOPTED

On motion of Dr. J. F. Moon, Baraboo, seconded by Dr. J. A. Hurlbut, Madison, carried, the following standing rules, as adopted in previous sessions, were approved for this session:

1. Without permission of the House, reports of officers be limited to twenty minutes.
2. Without permission of the House, supplementary reports of committee chairmen or members be limited to five minutes.
3. Rule 7, Roberts' Rules of Order (1915 Ed. p. 39) be modified by the provision that no member can speak longer than five minutes at a time in debate without permission of the House.
4. The Committee on Nominations shall remain in open session for one hour to hear any delegate or alternate (or other member of the Society) who may have suggestions, after which it may proceed in closed session.
5. Roll calls:
   a. An alternate delegate is alternate for a specific regular delegate and cannot serve as a "roving" alternate delegate.
   b. There is no provision recognizing bloc voting by a county society. On roll call, individual delegates or alternate delegates or specially appointed delegates will be specifically polled as to their vote.
   c. If a delegate registers but is absent for some portion of a session, his alternate delegate cannot vote. Once the delegate registers for one of the three sessions, he is the accredited representative of the county society for the duration of that session.
   d. If an alternate delegate first registers with credentials that have been supplied him, and is recorded on the report of the Credentials Committee, and some time during the course of the session the regular delegate appears, it is the alternate delegate who is entitled to vote.
   e. At the 1949 session, the House approved the motion that in order to facilitate contested elections in the future, the system employed by the American Medical Association be utilized wherein the roll call of registered delegates is called from the Speaker's rostrum, and as the name is called, the delegate or alternate comes up and deposits his ballot, so that there can be an accurate count against registration.

Reports of Officers

REPORT OF THE COUNCIL

The following report of the Council was published in the Delegates Handbook:

The Council is the Board of Trustees of the State Medical Society, and under provisions of Article VI of the Constitution it has full authority and power of the House of Delegates, between annual sessions, unless the House of

Delegates shall be called into session as provided in the Constitution and By-Laws. The chairman of the Council, under provisions of Section 1, Chapter VI of the By-Laws, "shall make an annual report to the House of Delegates."

Full details of each Council meeting are published in the Wisconsin Medical Journal, and this report, therefore, is a summary of activities and developments since the October, 1951, annual meeting of the House of Delegates.

Interim Committee

The Interim Committee of the Council, which is composed of the president, president-elect, chairman and chairman emeritus of the Council, and three members elected by the Council, has met in six sessions during the period from November, 1951, through July, 1952. It has considered numerous matters of noncontroversial character and has advised the secretary's office as to the proper method of handling them. In addition, it has reviewed many matters of great importance to the Society and has made its recommendations to the Council, which in turn has given its consideration and advice.

It has been the effort of the committee to aid the Council and the secretary's office to handle expeditiously questions and problems presented to it, and in so doing, it has been able to relieve the Council of much detailed consideration of routine matters.

Speaker and Vice-Speaker

It was with considerable regret that the Council learned of the death in January of Dr. Byron J. Hughes, Winnebago, speaker of the House of Delegates. Doctor Hughes had given many years of service to the Society through committee activities and delegate representation, and his passing is a distinct loss to the Society.

With the succession of Dr. H. Kent Tenney to the office of speaker, the position of vice-speaker was left vacant; and in accordance with authority granted it by Chapter VI, Section 7, of the By-Laws, the Council appointed Dr. W. D. Stovall, Madison, to fill the unexpired term of Doctor Tenney as vice-speaker.

Commission on Prepaid Plans

One of the most important activities within the Society's structure at the present time is that of the Commission on Prepaid Plans, created by the Council in November, 1951, and reported in detail in the December, 1951, Journal. This Commission is charged with the duty of directing the several activities in the prepaid plan field, including Wisconsin Physicians Service and the Wisconsin Plan.

A report of the Commission is separately submitted.

Council on State Departments

The Council believes it timely and appropriate to recommend to the House of Delegates its serious consideration of the elimination of certain standing committees and the assignment of the duties of those committees to Council direction.

Recent years have seen the development of health bureaucracy in the federal government to a point almost beyond belief. More than 40 different federal agencies render federal medical service. Developments within the state government are neither as marked nor as dramatic. Yet, they exist; and in the belief of the Council a more realistic program within the medical profession is required in order to keep abreast of current programs in advance of current trends and in a position of greatest assistance in the public health picture.

The State Department of Veteran Affairs has within its statutory authority certain responsibilities in extending financial assistance to veterans and their families to protect their economic status, when they are in need of health services.

The State Department of Vocational Rehabilitation has somewhat similar responsibilities and programs, and that field has the assistance of federal aid.

The State Department of Public Instruction has a bureau, the responsibilities of which are directed to the care of the crippled child, while in the State Board of Health there are bureaus dealing with maternal and pediatric problems.

While the State Department of Public Welfare and its policymaking board, the State Board of Public Welfare, deal more in fields of philosophy and less in fields of actual administration, nevertheless, both are of consequence and of tremendous importance.

Under the Constitution and By-Laws at the present time, there exist Standing Committees on Goiter, Care of Crippled Children, Maternal and Child Welfare, Tuberculosis and Chest Diseases, Mental Hygiene and Institutional Care, Visual Defects, and Hearing Defects. In addition, due to recent developments, the Council has organized a Committee on School Health and has had for several years a Committee on Venereal Diseases. It is the function of each of these several committees to advise cooperating agencies of the state government in the several fields indicated by the name of the committee itself.

The Council has been of the opinion that the weakness of this type of committee structure lies in two principal points, the first being that each committee serves in a specialized field without the opportunity fully to recognize the part which that particular field plays in the total picture, and the second being that as one of these particular interests tends to become dormant, a standing committee continues by virtue of the fact that it is a creature of a By-Law and neither the committee itself nor its functions can be discharged without By-Law amendment.

The Council itself desires no further responsibility than it already possesses; but it would be lacking in fulfillment of its responsibility if it did not point out to the House of Delegates the essential weakness of this particular phase of the Society committee structure and emphasize its belief that assignment of these duties to the Council would tend to coordinate and correlate Society activities and maintain them in constant relation to the needs of the state government and to the needs of public health.

The Council recommends to the House the elimination of By-Law mandate that these committees exist as standing committees of the Society and that it consider as an alternative to the present unwieldy and burdensome structure, that the Council itself create as a special Council committee a "Council on State Departments." Such a Council would assume all duties of the several committees mentioned herein and report as frequently as necessary to the general Council and through it to the House of Delegates.

If this particular report is accepted by the House of Delegates, the Council will proceed promptly with the organization of a Council on State Departments, with broad authority to that Council in the development of its own particular structure, such as divisions on public assistance, public health, school health, institutional care, and vocational and rehabilitation programs. It is the belief of the Council that this will serve best to further the program of the Society, and to that end the Council recommends to the House of Delegates the following resolution:

"*Resolved,* that Sections 7, 8, 9, 10, 12, 15 and 16 of Chapter VII of the By-Laws be repealed, that the present membership of the several committees be extended the thanks of the House of Delegates for their effective and interested work on behalf of the profession, and that the duties of these several committees be assigned to the Council of the State Medical Society."

Quorum of the House of Delegates

At the present time, Section 3 of Chapter III of the By-Laws provides that one-fourth of the members of the House of Delegates registered, shall constitute a quorum of the House of Delegates. The Council recommends that such one-fourth shall also represent one-fourth of the county medical societies in the state. It therefore offers the following resolution:

Resolved, that Section 3, Chapter III of the By-Laws be amended as follows: (italicized material new)

"One-fourth of the members of the House of Delegates registered, *representing one-fourth of the county medical*

societies in the state, shall constitute a quorum of the House of Delegates. All meetings of the House of Delegates shall be open to members of the Society."

Epilepsy and Marriage

The Council has considered a recommendation of the Subcommittee on Epilepsy and Marriage of the Committee on Mental Hygiene. It proposes that the Committee on Public Policy introduce legislation which will revise the wording of Section 245.03 (1) of the Wisconsin Statutes so that the words "epileptic person" be deleted from the Section, which reads in part: "No insane, imbecile, feebleminded or epileptic person or idiot shall be capable of contracting marriage."

It was the subcommittee's opinion that the epileptic person is a normal person except for his epileptic seizures, and in no wise is he a mentally ill person.

The Council has concurred with this opinion, and has referred the matter to the Committee on Public Policy for development.

Committee Concentrates

Members of the Society have undoubtedly noted a new section in the Wisconsin Medical Journal entitled "Committee Concentrates." Inclusion of this section was recommended by the Interim Committee and approved by the Council. It contains a brief report of activities of various committees of the Society each month.

Conferences With State Boards

The Council has requested that annual conferences be held with members of the State Board of Health, the State Board of Public Welfare, and the State Board of Medical Examiners, and that biannual conferences be had with Wisconsin delegates to the American Medical Association, for the purpose of discussing matters of mutual interest, and in the latter case to review matters scheduled for consideration by the House of Delegates of the American Medical Association.

For several years, conference has been had with members of the State Board of Health at the time of the Annual Meeting of the Society; and at the time of the May Council meeting, representatives of the State Department of Public Welfare met with the Council. It has not been possible to schedule a meeting with the State Board of Medical Examiners as yet.

At the November and May meetings of the Council, matters to come before the American Medical Association House of Delegates were discussed with the Society's delegates. Information available at the time of these Council meetings, held the month before the AMA meetings, was reviewed in detail.

The Council was also invited to view a specially prepared exhibit on medical history at the State Historical Society; and at the time of its May meeting, a personal visit was made by councilors, officers, and invited guests.

Who's Who in Health Field

The Council has approved a proposal that the January, 1953, issue of the Wisconsin Medical Journal contain a section entitled "Who's Who in the Health Field in Wisconsin," which will list agencies such as the Heart Association, Cancer Society, Hospital Associations, organizations for the care of the chronically ill, blind, deaf, and others, together with pictures of their president and secretary.

The Council has asked that this section of the January Journal be developed and submitted to the Interim Committee before publication.

Building Program of Society

When the present office building of the Society was acquired three years ago, the Society did not contemplate the removal of the Wisconsin Physicians Service staff from Milwaukee to Madison. However, this was directed by the Council in the summer of 1950, with the consequence that more than 25 persons are now located in the Society's building in administration of that plan, in addition to other Society employees. The number of employees must inevitably increase as the Blue Shield plan continues to grow.

Expansion proposals have been discussed with the Interim Committee and the Council from time to time. The Council has granted broad powers to the Interim Committee to make final decisions relating to acquisitions of property, to retain architects for the purpose of making preliminary studies of the type of structure which might be feasible and its estimated cost. All findings are to be reported back to the Council for final determination.

General Problems

The chairman of the Council has suggested the advisability of providing time on the agenda of Council meetings for discussion of problems and matters of general interest to the profession. Councilors could thereby bring in thoughts of those whom they represent for a general discussion of problems of medical practice.

R. G. Arveson, M.D.
Chairman

REPORT ON NECROLOGY

The Council reports with sorrow the deaths of the following physicians since the last Annual Meeting. Members of the Society are indicated by bold-face type.

Ackermann, William ----------Milwaukee
Altenhofen, A. R. ----------Wauwatosa
Andrews, M. P. ----------Manitowoc
Baehr, L. T.-----Madison
Barnes, H. T.----Delafield
Baugh, C. W. -----Menomonee Falls
Blair, J. F.----Milwaukee
Bowing, I. E.----Kenosha
Campbell, Douglas --------New Richmond
Cremer, V. H.-----Tomah
Dockery, E. E. Virginia Beach, Virginia
Dull, C. F. -------Richland Center
Eagan, R. L.----La Crosse
Eggers, G. C.--Two Rivers
Eisenberg, J. J. ----------Milwaukee
Fallis, R. E.---------Fort Townsend, Washington
Finnegan, W. L.--Wonewoc
Fitzgibbon, William ----------Milwaukee
Gates, A. J.------Tigerton
Gillette, H. E.-Pardeeville
Grotjan, W. F.-Milwaukee
Gulbrandsen, L. O. ----------Viroqua
Harder, Henry-Milwaukee
Holland, H. J. ------Mukwonago
Hood, A. J.----Milwaukee
Hughes, B. J.--Winnebago
Irwin, G. H.---------Lodi
Ison, G. W.------Crandon
Jandrain, R. R.-Luxemburg
Janney, F. R.--Wauwatosa
Kenney, H. J.----Delavan
Kliese, L. A.--------Omro
Krueger, Bernard ----------Milwaukee
Leicht, Phillip--Lake Mills
Macauley, E. M.--Wausau
Maercklein, O. W. C. ----------Milwaukee
Maes, C. G.-----Kimberly
Malone, F. A.--Waterford
McLaughlin, H. J. ----------Bloomington
Minoka-Hill, Lillie R. ----------Oneida
Mitchell, E. J. -------Sarasota, Florida
Mitchell, S. R.-Milwaukee
Mueller, W. E.-Green Bay
Murawsky, W. J. ----------Burlington
Oakland, H. G.-Milwaukee
Oberembt, B. H. ----------Milwaukee
Panetti, P. A.---Hustisford
Perrin, H. E.--Star Prairie
Reist, P. Z.--Girard, Ohio
Reynolds, J. H.-Milwaukee
Ridley, S. R.-Mineral Point
Savage, G. T.--Milwaukee
Schaefer, A. A.-Milwaukee
Schaefer, Carl O.---Racine
Schloemer, A. J. ------Menomonee Falls
Seeger, S. J.-Dallas, Texas
Senn, G. A.----Green Bay
Smith, J. F.------Wausau
Starnes, Brand-New Lisbon
Stranberg, W. L. ----------Wauwatosa
Strong, R. J. C.-Milwaukee
Teschan, R. A.--Milwaukee
Thill, G. E.----Milwaukee
Walters, D. N. ---------Fond du Lac
Williamson, C. S.--Arroyo Grande, California
Zivnuska, J. F.-Milwaukee

SUPPLEMENTARY REPORT OF THE COUNCIL

This report was presented by Doctor Arveson, supplementary to the printed report in the Handbook.

Under the provisions of Chapter VI of the By-Laws, the Council is required to meet on the day preceding the annual

session, in February of each year, and at such other times as may be necessary.

In its meetings on October 4 and 5 a number of matters were considered by the Council and are now reported to the House:

1. *The American Medical Education Foundation*—A resolution supporting this project follows. In summary, it calls upon physicians to contribute annually to the Foundation in support of medical schools, and instructs the printing of the list of contributors periodically in the Journal.

2. *The Student Loan Fund*—A resolution is presented the House instructing an immediate campaign to develop this Loan Fund to more effective size. The full resolution follows.

3. *Council Committees*—Eight Council committee reports follow:

a. Committee on Blood Banks
b. Historical Committee
c. Polio Consultants Committee
d. School Health Committee
e. Committee on Venereal Diseases
f. Veterans Medical Service Agency Committee
g. Committee on Civil Defense
h. Committee on Military Medical Service

In addition, the Council received a report relative to a report of the Committee on Care of the Aged of the Legislative Council which has concluded its recommendations to the Legislative Council and a number of these are expected to be presented for legislative action. Among them are proposals to create a Division on Chronic Diseases and Geriatrics in the State Board of Health which will be charged with developing educational programs relating to nutrition, physical examination, research, and rehabilitation as these matters relate to the aged and aging. In addition, the committee of the Legislative Council recommends a continuing specialized study as to the costs of all medical, hospital, nursing, and other care extended to the aged with emphasis on the possibility of developing a program in which these health costs will be established on a uniform basis applicable to all areas of the state.

This is an involved field in which it would appear that the development of public assistance in these several fields on a state-wide basis is imminent. In Minnesota, legislative power has been granted Blue Cross and Blue Shield to enter into these fields, and this power is already a statutory grant to the State Medical Society of Wisconsin.

Because the legislature will be in session within a short period of time, it seems wise that full implications of the committee's report be considered at an early date and reported back to the Council at its November 1952 meeting.

Finally, the Council reports its consideration of a matter relating to the organization of this House. In the late thirties, Chapter XII of the By-Laws was enacted to provide for formally recognized sections with delegate representation. Since passage of that By-Law, 10 sections have been created and there is every reason to believe that more will follow. The mechanism for the election of delegates has always been vague, and on some occasions specialty societies have actually taken over this function.

The Council directed a special committee, composed of Drs. E. L. Bernhart, Milwaukee; H. E. Kasten, Beloit; and H. Kent Tenney, Madison, to consider the matter.

This committee recommends that the sections be directed to comply with the By-Laws that membership requirements in sections be submitted to the Council for approval.

In addition, the committee recommends that section delegates be without right to vote, but have all other privileges accorded delegates.

This will assure that the House will continue as a democratic organization of all physicians, regardless of their general or specialty practice, and as those physicians are grouped in their county medical societies. To accomplish the objective of this report, it is recommended to the House that the words, "but such delegates shall be without vote" be added to the last section of Chapter XII of the By-Laws.

A Resolution on The American Medical Education Foundation

WHEREAS, many American medical schools are operating with deficits as a result of reduced incomes from endowments, rising costs and depletion of reserves, and many are faced with the prospect of curtailing their facilities unless substantial added financial support is forthcoming, and

WHEREAS, this situation must be met either by donations from the medical profession and other citizens or grants by the federal government, and

WHEREAS, the American Medical Education Foundation was established by the American Medical Association to secure adequate, unrestricted funds for medical education from voluntary sources, and this fund has already turned over more than $1,400,000 in contributions to the nation's medical schools and is now seeking annual contributions of $2,000,000 for the same purpose, and

WHEREAS, the American Medical Association, which annually contributes $500,000 to the fund, urges individual physicians to supplement this amount with contributions of $100 annually, and the success of the program to obtain contributions from physicians will spur significant contributions from industry, business, agriculture and labor, now therefore be it

Resolved, that every member of the State Medical Society of Wisconsin demonstrate his support of continued high quality medical education by contributing annually and generously—each according to his means—to the American Medical Education Foundation.

And be it further resolved, that there be published periodically in the *Wisconsin Medical Journal* the list of Wisconsin physicians contributing to such fund, and

Be it finally resolved, that this resolution be sent each member of the Society and periodically published in the *Wisconsin Medical Journal* with the reminder that physicians may, if they wish, "earmark" their individual contributions for a medical school of their choice.

Resolution on Student Loan Fund

WHEREAS, the modern medical student is faced with an average expenditure in excess of $1,500 annually in connection with his medical training; his curriculum is so exacting that most available time should be spent in study; the length of his course of study often results in his assuming family responsibilities before attaining his medical degree —all of these facts contributing to a situation in which a number of the 600 students in the two Wisconsin medical schools need partial or full financial support if they are to complete their education, and

WHEREAS, the Student Loan Fund of the State Medical Society was established in August 1951 as an instrument to assist needy and deserving medical students, interns and residents, with preference being given to those attending the University of Wisconsin Medical School and Marquette University School of Medicine, and

WHEREAS, a fund of $250,000 is needed by way of contributions from physicians and the public if the program is to be effective and financially sound, now therefore be it

Resolved, that the State Medical Society of Wisconsin conduct, during the next year, an intensive, county-by-county, mail and personal contact solicitation program among the physicians of Wisconsin, and later a separate public solicitation, as a means of accumulating sufficient capital to permit the Fund to operate effectively.

Committee on Blood Banks

W. D. Stovall, chairman; C. N. Neupert; and T. J. Greenwalt

This committee was appointed by the Council in 1950 to study the advisability of setting up standards for the operation of blood banks, and to review periodically the status of the blood procurement programs in Wisconsin and advise the Council and the House of Delegates as to any changes or modifications of the program which should be made in the best interests of civilian and military requirements.

During the past year this committee has met once and has come to the conclusion that its primary function is to serve in an advisory capacity to the medical directors of the Red Cross Regional Blood Centers serving Wisconsin hospitals, and to assist any local group seeking advice as to special problems encountered locally in the procurement and proper use of blood.

In evaluating the work of the Red Cross blood procurement program it is important to note that following World War II, when a decision had to be made regarding the responsible agency to procure blood on a state wide basis, there was a reluctance on the part of many physicians and public health officials to assume this responsibility. The Red Cross offered its services, and they were accepted. Now many physicians and hospital officials are critical of the services being rendered by the Red Cross, which appears to the committee an improper attitude to take. So long as the Red Cross has been designated as the official agency for the procurement of blood for military needs, it should suggest the desirability of providing local medical supervision with sincere cordiality.

A review of the procurement program during the past year suggests that in certain areas the medical profession and hospital administrators are not giving proper evaluation as to the proper conservation of blood, with resulting waste and a depleted supply, where with proper utilization the amount would be adequate to meet both civilian and military needs. A report from the Red Cross indicates that some hospitals are returning a very large percentage of their orders as unused blood, which suggests that hospitals are not properly anticipating their needs and placing orders for blood which are in considerable excess of the amount required. In other instances physicians and hospitals are using blood in quantities which would suggest that the supply is limitless. While the use of blood should be encouraged whenever needed to insure the recovery of the patient with actual need for blood replacement, the profession should be warned to use thoughtful discretion in ordering blood for various procedures.

The Committee on Blood Banks is of the opinion that hospitals can get assistance and advice concerning the technical practices carried on in their blood banks from the Wisconsin Association of Blood Banks. It is a state association which is affiliated with the National Association of Blood Banks, and these organizations are prepared to assist any hospital which wishes to set up its own blood program. All hospitals providing this service independent of the Red Cross are urged to affiliate with the Wisconsin Association of Blood Banks, so that they can exchange experiences with other members of the organization, and thus derive benefits which will be reflected in better service to their patients.

Recommendations

(1) That all county medical societies and local medical groups in urban areas set up medical advisory committees which will actually function and give proper medical direction and supervision to local blood procurement programs of the Red Cross.

(2) That all hospital staffs utilizing blood from the Red Cross program set up a responsible committee to evaluate the use of blood, to see to it that it is not used to excess, and that the percentage of unused blood can, if possible, be held to an optimum of 10 per cent or less.

(3) That all hospitals which maintain their own blood banks, affiliate with the Wisconsin Association of Blood Banks and secure the benefits of cooperative planning and the exchange of experiences.

(4) That hospitals be encouraged by medical staffs to keep a card file on blood types of each patient and possible availability for use in event of a major disaster.

(5) That the Committee on Blood Banks be continued and serve in an advisory capacity to the Red Cross Regional Blood Centers and any local blood bank desiring services or information which the committee can provide.

Historical Committee

H. K. Tenney, chairman; P. R. Minahan; E. M. Dessloch; N. J. Wegmann; E. E. Kidder; G. K. Tallmadge; and E. H. Ackerknecht

The primary function of this Council committee has been the direction of the historical project conducted in cooperation with the Wisconsin State Historical Society through the part-time employment of a graduate student who is particularly interested in gathering together and cataloging significant historical material directly connected with advances of medicine in Wisconsin.

This project has been carried on for the past year and one-half, with the termination of special assistance on the part of the graduate student scheduled for next summer. During this time a wealth of heretofore unknown material of historic value has been unearthed and much of it transferred to the State Historical Society building in Madison. Other materials, which properly could be preserved locally and are being handled by responsible local branches of the State Historical Society, have been retained in the individual localities but cataloged at the State Historical Society so that the source and location of the material are kept in a central file.

The major effort of the research student has been to gather records of county societies, of such organizations as the Homeopathic Medical Society of Wisconsin Minute Book from 1865–1910, the history of the Wisconsin Anti-Tuberculosis Association, and the records of living pioneer physicians.

While a research project of this type could naturally be a continuing effort, it does not seem practical to continue the program on the same basis as during the past year and one-half. Following termination of direct assistance on the part of the graduate student now employed, it is suggested that the Historical Committee continue contact with older physicians, as a means of preserving records and securing as much material of lasting value as possible to be housed in the archives of the State Historical Society, where it is hoped to have a special section devoted to medical history.

The decline of interest on the part of the Beaumont Foundation in Prairie du Chien to further support the restoration of the old military hospital where Doctor Beaumont conducted some of his famous experiments on gastric processes has suggested the possibility that the State Medical Society acquire the deed to the property and develop it into a medical museum, operated jointly with Villa Louis, under the custodianship of the State Historical Society. The matter has been referred to the Interim Committee for further information and recommendations.

Recommendation

That county medical societies take an interest in preserving the records and historical materials of their members and their society through the appointment of a single individual who will be sufficiently interested in the matter to secure records which should be kept for the medical history of Wisconsin and the State Medical Society.

Committee on Polio Consultants

H. W. Wirka, chairman; R. S. Baldwin; R. F. Poser; Marvin Steen; and Kenneth McDonough

This committee was appointed in 1950 at the request of local representatives of the National Foundation for Infantile Paralysis. Its purpose was threefold: (1) to assist in the compilation of a panel of qualified physicians who would agree to serve as consultants to confirm the diagnosis of poliomyelitis; (2) to serve in a special consulting capacity during hospitalization of the patient to determine the extent of involvement and make recommendations for therapy; and (3) to make a final evaluation of the patient prior to discharge from the hospital, and determine the course of treatment in the home.

This specific project was completed, and a list of such consultants made available to all physicians, nurses, and local chapters of the National Foundation. It was the rec-

ommendation of the special committee that an expanded committee be set up to serve in an advisory capacity to the state representatives of the National Foundation. However, as no request for such service has been received, it is recommended that the special committee of 1950 be dissolved and discharged from further duties.

Committee on School Health

F. J. Mellencamp, chairman; W. R. Manz; A. C. Edwards; E. B. Pfefferkorn; and Amy Louise Hunter

The primary function of this committee has been to serve in an advisory capacity to health educators of the Department of Public Instruction and the State Board of Health. This past year there has not been need for a formal meeting, as the primary project of the year, that of planning a state conference on "Physicians and Schools," has been done by a special planning committee, with the chairman of the Committee on School Health as a member.

For the past six years the American Medical Association has sponsored a national conference on "Physicians and Schools" every two years, with a recommendation that states set up similar conferences on a state basis. Such a conference is to be held in Madison on October 17–18, and it is hoped that many physicians will attend and take an active part in the discussion. School administrators and special staff members immediately concerned with health problems have responded well to the invitation of the State Medical Society to take part in this conference, and it is essential that many physicians attend and show a sincere desire to have the medical profession solve some of the problems confronting school boards and school officials. The Committee on School Health invites the participation of all members of the State Medical Society to this important conference.

Committee on Venereal Diseases

Stephan Epstein, chairman; J. M. King; P. C. Gatterdam; O. A. Stiennon; and G. A. Cooper

This committee has not been active this past year, but it should be kept as a Council committee to meet changed situations as they arise.

Since the last report of this committee was made, the various district clinics have been closed; and emphasis has been placed on the responsibility of the individual physician treating venereal diseases as a part of his practice, through intensive use of the antibiotics. The committee issued a recommended course of therapy to the profession in the form of tip-ins and accompanying articles inserted in the *Wisconsin Medical Journal* (Cooper, G. A., M.D., "Diagnosis and Treatment of Syphilis," October, 1950, pp. 911–14; Gatterdam, P. C., M.D., "Present Day Treatment of Gonorrhea," December, 1950, pp. 119–20; Rowe, Richard J., M.D., "Present Day Treatment of Chancroid, Lymphogranuloma Venereum, and Granuloma Inguinale," December, 1950, pp. 1120–22.)

It is suggested that this committee be retained as a Council committee with possible reconstruction of committee membership to include a representative from the Department of Health of the City of Milwaukee and the faculty members of the two medical schools who are most immediately concerned with this problem in relation to teaching services.

Year	Syphilis	Gonorrhea	Chancroid	Other VD
1941	1010	875	2	
1942	970	704	13	
1943	1053	940	0	
1944	866	1168	4	
1945	2260	1844	0	0
1946	2449	1676	25	98
1947	2107	1247	9	1
1948	1976	960	6	4
1949	2411	745	9	1
1950	2203	737	4	0
1951	1866	825	2	8

The preceding table from the State Board of Health indicates the extent of various venereal diseases reported for the past two years. It shows need for continued alertness on the part of the medical profession.

The Wisconsin Veterans Medical Service Agency Operating Committee

J. S. Supernaw, chairman; Maurice Hardgrove; J. L. Moffett; W. A. Fischer; and Otto A. Dittmer

The State Medical Society of Wisconsin operates a program known as the Home-Town Care Program for the Veterans. It has operated continuously since 1946 in cooperation with the Veterans Administration.

TOTAL VALUE OF BUSINESS WITH THE VETERANS ADMINISTRATION

	July 1, 1951 through June 30, 1952	July 1, 1950 through June 30, 1951
Total authorizations received from the Veterans Administration	$167,782.50	$193,748.65
Total authorizations cancelled	17,392.74	19,989.75
Unused authorities	25,208.97	27,882.15
Total cash paid to physicians	134,750.96	136,709.02
Total amount received from Veterans Administration for administrative expenses	22,041.03	23,383.39
Number of doctors on panel	2,622	2,612

The contract existing between the State Medical Society and the Veterans Administration is on a year-to-year basis, and it operates on a cost basis for administration.

During the period from 1946 until the present time, there have been 10 districts within the state served by Veterans Administration clinic full-time medical staffs. At the present time, there is a clinic in operation in Green Bay and one in Milwaukee. The balance have been closed, and the Agency's committee feels it is a distinct advantage, because now the veterans in these other areas have more opportunity to choose their own physician for the medical care of their service-connected disabilities.

At the May 4, 1952, meeting of the Wisconsin Veterans Medical Service Agency Committee, resolutions were considered as submitted by other state societies and the American Medical Association regarding those with non-service-connected disabilities in Veterans Administration hospitals.

A letter from Dr. George F. Lull of the American Medical Association was read advising that a study is being made in respect to the following as the basis for policy recommendations to the Board of Trustees and the House of Delegates of the American Medical Association:

a. Medical and hospital benefits for veterans with non-service-connected disabilities.

b. Medical and hospital benefits for dependents of service personnel; and

c. Transfer of seriously disabled personnel from service hospitals to Veterans Administration installations.

Resolutions from the Arkansas and Tennessee state medical associations were read expressing disapproval in the use of Veterans Administration facilities for veterans with non-service-connected disabilities, and motions of Doctor Fischer–Moffatt, carried, the committee recommended to the Council that the study be made by the American Medical Association and that the substance of the Arkansas and Tennessee resolutions be supported by the State Medical Society of Wisconsin.

These resolutions were discussed with the Council of the State Medical Society of Wisconsin and were passed, and information regarding them and findings of the Council was made available to the delegates from Wisconsin representing the State Medical Society in the House of Delegates of the American Medical Association.

CERTIFIED FINANCIAL STATEMENT

June 30, 1952

Assets

Current Assets		
Cash in Bank—Administrative Fund	$4,704.77	
Cash in Bank—Medical Fund	4,770.73	
Petty Cash	10.00	
Medical Claims Filed with Veterans Administration	4,950.59	
Administrative Claims Filed with V. A.	1,621.42	
Total Current Assets		$16,057.51
Fixed Assets		
Office Furniture and Fixtures	$2,434.17	
Less: Accumulated Depreciation	1,300.21	
Total Fixed Assets		1,133.96
Prepaid Expenses		
Unexpired Insurance		29.85
Total Assets		$17,221.32

LIABILITIES

Current Liabilities		
Due Doctors on Claims Filed	$9,721.32	
Total Liabilities		9,721.32

Advance From State Medical Society of Wisconsin

Balance of Cash Advance—June 30, 1952	$ 7,500.00

CERTIFICATE

I have audited the accounts of the Wisconsin Veterans Medical Service Agency, an Agency of the State Medical Society of Wisconsin, Madison, Wisconsin, for the period January 1, 1952 to June 30, 1952, and,

I hereby certify that, in my opinion, the above Financial Statement correctly represents the financial condition of the Agency on June 30, 1952, and the result of its operations for the period January 1, 1952 to June 30, 1952 in conformity with generally accepted accounting principles.

/s/ DONALD E. GILL
Certified Public Accountant

Madison, Wisconsin
July 19, 1952

Committee on Civil Defense

M. J. Musser, Jr., chairman; E. P. Ludwig; K. E. Lemmer; J. S. Wier; and E. A. Bachhuber

"On December 7, 1941 . . . our store of blood plasma . . . was inadequate . . . our Office of Civil Defense existed only in skeleton form and largely on paper. Only the medical defense offices, under the auspices of the Medical Preparedness Committee of our county medical society, were actually organized and operating. The inevitable confusion that follows an enemy attack, makes the organization and establishment of a local O.C.D. many times more difficult then, than during 'peacetime.' The lesson is obvious."

This lesson should be equally obvious today, although the foregoing statement was made by the Hawaii Territorial Medical Association in January, 1942.

The world seems destined at this point to a state of continued conflict. The plans and preparations being made against wars, which might suddenly break upon us without warning or which follow a series of 'so-called "incidents," must be paralleled by civil defense plans and preparations. It should not be necessary for this committee to remind the profession that the technological advance of weapons of destruction has taken the question of enemy attack from the realm of improbability to the area of distinct possibility. It would appear that civil defense is here to stay and must become an accepted part of the responsibility of the medical profession for the welfare of the people.

The threat of an atomic attack in Wisconsin is completely uncertain and unpredictable. Yet, as long as the existing chaotic world situation remains and enemies continue to arm themselves with more and more formidable weapons, the threat persists. We would be ill-advised indeed if we did not pay heed to the circumstances and possibilities as they exist and mobilize such resources for our defense and protection as are necessary.

This can be accomplished realistically and effectively if everyone assumes his share of the responsibility. However, the major obstacle at the present time is the reluctance of the public at large to wholeheartedly participate in a program that might assure adequate preparedness. The committee has made every effort to view civil defense in terms of the practical and realistic, and to provide to the physicians of Wisconsin the instructional material which might better acquaint them with the role they must play.

In Wisconsin, civil defense is viewed as a primary responsibility of our state and federal government. In the event of enemy action the problem of supplies, equipment and materials beyond the first few hours must be a government responsibility. There is central purchasing authority, and supplies are being stockpiled and distributed within easy reach of critical target areas. Only essential supplies are being stockpiled, for it is impossible to provide for every conceivable emergency.

Civil defense planning in Wisconsin has made considerable progress during the past year, and your committee has made every effort to guide this planning into fields that are reasonable and responsible. As a result, it is believed that loose thinking has been eliminated from civil defense planning in this state.

One of the major objectives of civil defense in Wisconsin is to minimize the effectiveness of an enemy attack, if it does come, by saving lives, relieving suffering, maintaining production for the Armed Forces and assuring a sustained high level of morale. In event of a disaster, each individual must know what to do to protect himself and to administer aid to others. Beyond the individual, communities must assume responsibility and organize their resources and train their citizens for their own protection. Civil defense plans will vary considerably in accordance with the potentialities of the community as a military target. Each community must be prepared, however, to assist other stricken areas. This mutual assistance principle is the basis for planning in rural localities. It is obvious that a certain degree of uniformity in basic planning and operations is essential.

The State Office of Civil Defense has been established to provide a basis for the planning and coordination of efforts and resources. A co-director of health services is responsible for medical matter. He is Dr. C. N. Neupert, state health officer.

To enhance coordination of intercommunity and state efforts and to expedite the mobilization of relief facilities, the state has been divided into eight defense areas, each with a civil defense director and a medical director. These individuals assist communities with their planning and regulate mutual relief activities in event of a disaster. Within each area, and as a part of the state civil defense organization, a mobile defense battalion has been organized composed of all elements necessary to supplement a community's relief efforts. In each of these eight mobile defense battalions is a number of medical units. Today, these total 102, each identical in organization and basic equipment. When called upon, these medical teams will supplement community efforts, render emergency treatment to casualties, and initiate their evacuation to hospitals. When the need exists, some of these units will operate casualty holding stations, ambulance loading points, and auxiliary hospital establishments. Their organization is such that they can be augmented with technical personnel and equipment to broaden the scope of their functional abilities. They are the key to the success of the medical relief efforts.

The responsibility of the medical profession in civil defense, particularly in the organization of these 102 medical teams, is tremendous. The challenge can be met only by

the wholehearted support, interest, and cooperation of all physicians. Realizing the responsibility of the medical profession, your committee has been active during the past year with programs and advice designed to assist physicians in the formation of mobile defense medical teams and the organization of local community disaster relief programs. Without question, the single most important contribution of the committee to the civil defense effort thus far has been the preparaion of material for a special civil defense edition of the *Wisconsin Medical Journal* which was published in June, 1952. In this issue were brought together for the first time in Wisconsin the state civil defense plans as they relate to the emergency treatment of disaster casualties, hospital treatment of disaster casualties, medical aspects of atomic warfare, defense against biologic agents employed in warfare, the relation of the physician to civil defense planning in Wisconsin, the operation of a mobile medical team, the roster of mobile medical team captains, the Milwaukee County medical civil defense plan, the relation of the local hospital to civil defense, the problem of medical supplies for mobile medical teams in the state civil defense program, and special articles relating to other aspects of civil defense. This issue of the Medical Journal is being used as a guidebook for the organization of health aspects of the entire civil defense program.

The committee has been instrumental in bringing about the procurement of minimum essential supplies needed for the 102 mobile medical teams. Today, more than $335,000 in medical team supplies have been ordered through federal procurement agencies. Already a considerable quantity of litters, blood donor sets, drugs and other medical supplies and equipment have been delivered to Wisconsin and are now being stored at Camp Williams. As soon as the remainder of the supplies arrive, they will be boxed into units, complete and ready for the use of mobile medical teams should an emergency arise. These units will be stored at places convenient to the medical teams in various areas of the state.

Arrangements are now being made to procure 71,000 units of dried plasma through the Junior League Blood Center of Milwaukee. Funds have been allocated for this project, and it is expected that the supply will soon begin to build up. Meanwhile, the federal government is storing plasma in nearby states to be of assistance to Wisconsin in the event local supplies are insufficient.

Plans are also being worked out through a blood plasma procurement subcommittee to make whole blood available at the casualty stations and to develop definite methods by which whole blood may be procured for hospitals to which casualties may be evacuated.

Your committee has also participated in the preparation of a manual of operation for mobile medical teams, the final version of which is now being completed. This manual will detail the functions and operation of the mobile medical team and will be of tremendous assistance to the physicians who serve as captains of these teams.

Similarly, the Medical Society committee and the State Office of Civil Defense are coordinating their activities with the hospitals so that evacuation of casualties from the disaster area will be to hospitals 80 miles from the target area during the initial stages of the emergency. Patients will be moved from there to more distant hospitals as it is found necessary.

The committee is pleased to report that the State Office of Civil Defense is making every effort to eliminate detailed paper work and planning from the assignments given to the medical team captains and their assistants. As much as possible, all correspondence and other paper work are being handled through the State Office of Civil Defense with the information being channeled back to the team captains.

In an effort to hasten the organization of mobile medical teams, the Civil Defense Office has recently secured the services of Dr. Warren H. Southworth, professor of education at the University of Wisconsin, who will concentrate on the development of medical teams during the next four and one-half months. The fact that the University of Wisconsin and the Civil Defense Office have seen fit to release him from his teaching duties for this purpose is indicative of the seriousness with which the problem is viewed.

Representatives have been sent to medical civil defense conferences sponsored by the Council on National Emergency Medical Service of the American Medical Association, and the results of these conferences have been incorporated in the state civil defense program to a large extent.

At no time has the State Medical Society or this committee received any state or federal funds for its civil defense activities, nor does it plan to request funds. The medical profession will do its job, as it has always done, as a civic duty and as a representative of the free enterprise system.

The committee wishes to impress upon the Council that it is the responsibility of every physician to be cognizant of the civil defense plans of his community and of the state and of the exact part he may have in them. He should acquaint himself with recommended procedures of treatment of atomic disaster casualties. Adequate knowledge of and training in his specific civil defense duties are essential to assure maximum use of his professional skill in the event of a disaster.

Individual physicians should encourage, and if necessary, assist in, the training of the large number of nonprofessional individuals whose services will be of critical importance in caring for the thousands of disaster casualties which may arise. His interest and activities in civil defense can do much to dispel the apathy and indifference which exist in many communities.

County medical societies have a vital role in civil defense since they provide a splendid medium for the presentation and discussion of pertinent instructional material and the coordination of planning and training for physicians of adjacent communities. It has been previously recommended that each county medical society establish a civil defense committee which should function in an advisory capacity to community and area authorities and which should also inform the State Society of existing medical problems relating to civil defense. It is within the province of the county societies to take such steps as are needed to assure that communities, which they represent, have realistic and adequate civil defense programs.

Much remains to be done in the establishment of a civil defense organization in Wisconsin which will operate effectively in the event of a disaster. If an enemy should attack us tomorrow, we would be able to mobilize a fairly formidable disaster relief organization. However, because of insufficient training, undependable personnel, inadequate equipment and supplies, and the confusion which would result, its efficiency might be seriously impaired. It is hoped that the solution of these problems will not have to await an enemy attack.

Although the full responsibility for an adequate civil defense organization in Wisconsin is not alone ours as physicians, we have a vital contribution to make, and we cannot relax until it has been done.

Committee on Military Medical Service

F. L. Weston, chairman; M. J. Musser; J. M. Sullivan; M. H. Steen; and O. G. Moland

When hostilities broke out in Korea, there were an estimated 203,000 physicians in the medical manpower pool of the United States. Of this number, about 7,600 physicians were on active military duty at the time.

Within a year this distribution changed drastically, and with it the activities of the Committee on Military Medical Service. Some 6,000 physicians began a 24-month tour of duty during the first year of the Korean fighting. Most of these were recalled Reserve Officers, and the others were registrants under Public Law 779, the so-called "Doctor Draft" law which became effective in October, 1951.

Today the Department of Defense estimates that it has about 13,500 physicians on active military duty. It should be pointed out that during World War II the ratio of physicians to troop strength in the Armed Forces reached

a high of six physicians per thousand troops. The over-all average ratio of approximately five physicians per thousand troops was maintained during World War II. However, since the outbreak in Korea, this ratio has been reduced to about 3.7 physicians per thousand troops through greatly improved utilization. As a result of these reductions, there have been about 5,000 physicians available during the past two years for civilian health services who otherwise would have been in military service, according to the Department of Defense.

The Korean hostilities are going into the third year. The 6,000 physicians who began their service during the first year of the Korean action are now being released, and it is expected that they will be coming back to civilian life in increasing numbers between now and June, 1953. Thus, physicians in Priorities I and II are being called to replace those being released from service upon completion of their tour of duty and to provide care for the growing number of casualties from Korea and the gradually increasing military population.

As a result of the Council's wise decision of a year ago in separating civil defense functions from military medical service, the members of the Committee on Military Medical Service have been free to devote their activities to counselling the Wisconsin Advisory Committee to Selective Service and the Reserve Branches. You will recall that it is the task of the committee to determine who is essential to the preservation of the health and welfare of the community. In this task the remarkable assistance and cooperation received from councilors and physicians at the county level have been invaluable. Only with their continuing advice and support can this committee function to the best interests of the profession and the public. These physicians have sought information for us at tremendous personal sacrifice, and there is no question that they face the decisions put upon them with gravity and humility.

Since October 16, 1950, a total of 942 physicians in Wisconsin in Priorities I, II and III have registered through Selective Service. Two hundred ninety-seven of these have already been processed by the committee, and the processing of the remaining 646 is just beginning. The following tabulation made on September 18, 1952, will reveal the disposition of these registrants:

Priority I Physicians

Total classified—238

1–D—In Reserves	44
1–C—In Service or Discharged after Service	80
1–A—Available, in Process	24
4–F—Physically Unfit	50
2–A—Essential	35
Deferred for Dependency or Other Personal Reasons	5

Priority II Physicians

Total classified—53

1–D—In Reserves	5
1–C—In Service or Discharged after Service	8
1–A—Available, in Process	18
4–F—Physically Unfit	5
2–A–Essential	13
Deferred for Dependency or Other Personal Reasons	4

Priority III Physicians

Total classified—532

1–D—In Reserves	0
1–C—In Service or Discharged after Service	0
Currently Undergoing Physical Examination and Consideration by the Advisory Committee	433
1–A—Available, in Process	4
4–F—Physically Unfit	1
Over Age 51	30
2–A—Essential	30
Deferred for Dependency or Other Personal Reasons	34

The committee wishes to emphasize certain facts of these statistics which explain the current induction picture, and to clarify the problem as it relates to the Priority III physicians who have just been ordered to physical examination.

Since October 16, 1950, a total of 238 Priority I Selective Service registrants (those trained at government expense or deferred to continue their education, with less than 90 days' active duty) have registered and been processed by this committee.

Of these, 148 have been considered available for service, of which 124 are either in the Reserves or on active duty. A total of 35 physicians in Priority I have been considered essential to the community, hospital or teaching institution. Continued evaluation of this group will undoubtedly find many of them available for service before Priority III physicians are called. The remaining 55 are divided between the physically disqualified and those who have been deferred for personal reasons not related to essentiality.

It is anticipated that all *available* Priority I physician registrants will be on active duty or in the Reserves by November 1, 1952.

Of the Priority II registrants (those trained at government expense or deferred to continue their education, with more than 90 days but less than 21 months' active duty) 31 have been declared available. Nine have been unable to meet physical qualifications or have received deferments for personal reasons. Thirteen are currently considered essential, and these, too, are under review—some of them undoubtedly to be considered available prior to the call of Priority III physicians. Because the Priority I pool of physicians is near exhaustion it is anticipated that physicians in the Priority II group will be subject to duty call after November 1, 1952. This group will probably meet current military requirements until early 1953.

In connection with the exhausting of the pool of physicians in Priorities I and II the committee has developed a policy which it wishes to bring to your attention. The committee feels that it cannot in clear conscience submit available recommendations on Priority III physicians which may result in their being called to duty unless it very carefully reviews the medical service requirements of the communities and institutions which now have physicians in Priorities I or II who are classified as essential. The committee wishes to point out that its early recommendations on Priority I and II physicians were made in light of the then existing needs for physicians for military services. Two years ago, the Advisory Committee to Selective Service and the Armed Forces was not aware of and did not have information which would lead it to believe that the demand for physicians would be so great as to require call-up of physicians in the lower priorities. During the past months this situation has changed and it is clear that Priority III physicians will have to be called into service early in 1953.

In light of this, the committee has felt it necessary to review carefully all Priority I and II physicians previously declared essential so that as nearly as possible, every reasonably available physician in these two groups may be called prior to the call-up of Priority III physicians. In this re-evaluation, the Advisory Committee has called upon its contact physicians, many times asking for several opinions on one individual. In this process final decision has frequently been at variance with some of the advisors. The decisions, however, have been made with what the committee hopes has been a just and fair evaluation of the need for physicians in Wisconsin as well as in the military.

The physicians having the greatest concern about their military status today are those registered in Priority III. These are men who have seen no service since September, 1940. In numbers alone they constitute the greatest single group of physicians currently being processed by Selective Service. The committee feels that it is essential that the Council and the House of Delegates have a clear understanding of this picture and its implications for the future.

The 646 Priority III physicians are currently being examined and classified to get these procedures out of the way in anticipation of the time when the need may arise for calling them. The 1–A classification received by each of these physicians is for purposes of physical examination only. It does not mean that the physician will be inducted. The possibility of this group being called depends upon the exhaustion of physicians in Priority II. The exact date is dependent on future activity of the Armed Forces and

the progress of the Korean conflict. On the basis of information received from the Department of Defense, your committee has been able to estimate that the first calls may be made on this group sometime in early 1953. Priority III physicians will be called on an age basis—youngest first. At present, there is every indication that calls may be made for physicians up to age 44, although this cannot be said to be a certainty.

Priority III physicians should understand that the examining center, which provides the physical examination, does not have authority to inform the registrant if he has or has not passed the examination. The examination report is forwarded to Fifth Army Headquarters in Chicago for determination. This usually requires six weeks' time. If Fifth Army questions the acceptability of the registrant, the examination report is forwarded to the Surgeon General's Office in Washington for final determination. This usually requires one to two months in addition.

When the results of the physical examinations are made known to this committee through Selective Service, it will submit a recommendation of essentiality or availability on all registrants who have been found to be acceptable for service. The notice of the physician's availability will be sent to him at the same time it goes to the local board.

It should be pointed out that most of the physicians from the graduating classes of 1952 and later will have had no ASTP or V-12 training and no military service subsequent to September 16, 1940, and will, therefore, be classified in Priority III. These will be eligible for duty on the basis of age. Thus, it should be reasonable to expect that the graduating classes of the future will provide the bulk, although not all, of the physicians required for military service, assuming that the military need for physicians remains at the present level.

The committee wishes to call your attention to two plans which have been developed through the American Medical Association and the National Advisory Committee to Selective Service for the replacement of essential Priority I physicians with Priority IV physicians.

Sometime ago the Illinois Advisory Committee developed a program which was later urged upon the Wisconsin committee and all other state advisory committees through the national headquarters. Under this program, the Advisory Committee would inform the community or hospital that the Priority I physician, who was currently essential to that community, was being deferred for a period of six months. If the community or hospital did not show evidence of making reasonable efforts to obtain a replacement for him within that time, the physician would be declared available. If a reasonable effort was made to obtain replacement, the physician would continue to receive six month deferments; and continuing evidence would be submitted that efforts were being made to replace him.

To date, your committee has not seen fit to adopt this policy for Wisconsin.

Another effort to obtain replacements for essential Priority I physicians and thus relieve them for military duty has been initiated by the Council on National Emergency Medical Service of the American Medical Association in cooperation with the Department of Defense and National Selective Service System. Under this program the three Armed Forces supply the American Medical Association with names of physicians scheduled to be released from service. The American Medical Association contacts each physician to find out where he prefers to locate his practice. The names of physicians who wish to locate in Wisconsin, for example, are sent to the Wisconsin Advisory Committee with the suggestion that these men be contacted and urged to locate in communities where essential Priority I physicians are now practicing, thus relieving these men for duty.

This committee has felt that such a program would place the committee in a procurement and assignment role which it should not have. To date, the committee has turned these names over to the State Medical Society's Placement Service, which sends each military physician the list of locations where physicians are desired.

However, the committee does suggest that the State Medical Society's Placement Service list those cities or communities which now have an essential Priority I physician practicing there. The committee feels that this procedure is fair and necessary in light of the fact that the physician currently classified as "essential" is essential by virtue of the position he fills and not as an individual.

More than 400 Reserve Officers in the Army, Navy and Air Force have also been processed through this committee. The ratios of their availability and essentiality are quite like that among the physicians processed under Selective Service. That is, their call-up is being made concurrently with the induction calls issued on physicians under Selective Service. The reserve branches have been highly cooperative with the committee in following the recommendations made to them.

The committee hopes that it has maintained an objectivity conducive to fairness and justice and at the same time related the demands of the military to the practical reality of community medical service problems and the ability of a united medical profession to serve the people.

REPORT OF THE PRESIDENT

PRESIDENT A. H. HEIDNER: Mr. Speaker, members of the House of Delegates, and guests: As I retire from the presidency of this great organization, and after 25 years of service on its Council in various capacities, it is difficult for me to refrain from reminiscing a bit.

I have watched the growth of the State Medical Society of Wisconsin from the time it functioned with one part-time secretary. I well remember when George Crownhart was engaged as our first lay secretary with a one or two room office here in Milwaukee. At that time the secretary conducted the Annual Meeting, published the *Wisconsin Medical Journal,* did what he could, with assistance from the legislative committee, to influence health legislation, and took care of the immediate needs of the medical profession.

Now our State Society has increased its staff, with assistants to more than 40 people. It has expanded its program to include postgraduate instruction for its members, and committee and staff contacts with every health agency in the state. It prepares the open panel for industrial firms, is engaged in an extensive public relations program, operates a radio broadcasting service, and conducts two prepaid insurance plans besides many other activities too numerous to mention.

I have often wondered whether all of this expansion was necessary and worthwhile. From time to time the Council, the Interim Committee, and the Audit and Budget Committee have examined very critically all of the activities of the Society in an attempt to eliminate any unnecessary committees and expenses.

While some of our activities have outlived their usefulness and have been abandoned, new opportunities for service to the public and the profession are constantly arising, and our program continues to grow.

As we grow, new problems arise; and new difficulties confront us.

First: At the present moment the rapid growth of our insurance programs has placed us in a situation which requires action. We are being crowded out of the home which we so proudly established four short years ago.

Our prepaid plans were adapted primarily to give people of low income groups an opportunity to budget against catastrophic illness. The satisfactory experience of our policyholders has created a demand for this type of insurance among people with higher incomes. Because this is our best defense against socialized medicine, I feel that it is imperative that we continue to expand this program. In order to avoid some of the difficulties experienced by other medical societies, it is essential that we keep Blue Shield under the direct management of our organization. This requires close proximity, preferably under the same roof with our state office, and will necessitate enlarging our present quarters. Plans for expanding our housing facilities are being developed. This program as now outlined will not affect the dues structure of the Society.

Second: We have found that there are too few available week-ends to permit all of our committees to meet often

enough for effective work. Most of the committee meetings are held on Saturday and Sunday for the doctors' convenience.

After careful study we have reached the conclusion that the most practical solution of this problem is to combine several committees, dealing with similar subjects, into one large group or Council. Under this plan a comprehensive program can be discussed and outlined by the larger group in one or two meetings a year. Individuals and subcommittees, with staff aid, can function between meetings.

This plan has worked satisfactorily in the field of insurance under our Commission on Prepaid Plans and in the public relations field under the Council on Medical Service.

You will now be asked to approve the formation of a Council on State Departments.

I believe that this is a move toward greater efficiency and should be adopted.

I wish to again call your attention to the expanded public relations program carried on this year. Many of you have participated splendidly in your various localities. As you know, we have had meetings on the state level with the officers and, in some instances, with the directing boards of the pharmaceutical, dental, and legal professions. We have also held our Press-Radio conferences. The foundation has been laid for better understanding and less friction between these groups and medicine.

To make this work most effective and lasting, this program should now be carried down to the local level. Some counties have already done this and have found that many friendships have been made, and greater harmony has resulted. I wish that every county society in the state would arrange meetings and programs with the county dental and bar associations, as well as with the pharmacists and press and radio people.

Finally, I want to thank you most sincerely for the great honor you have shown me by making me your president. I have taken my duties seriously, have worked as hard in carrying them out as my strength would permit, and hope that I have accomplished something for the good of medicine and the public health in Wisconsin.

I appreciate the many courtesies you have shown me, the willingness with which every one has responded when called upon for help, and the fine spirit which exists throughout the state in Medical Society work.

Doctor Griffith has worked with me throughout the year most cordially. He has had much experience in medical affairs and has a genuine friendly personality which has made me appreciate his friendship very highly.

I know that all of you will appreciate him, as I do.

I wish him the greatest success in his new position as your president.

REPORT OF THE PRESIDENT-ELECT

The report of the president-elect, Dr. J. C. Griffith of Milwaukee, was published in the November issue of the *Wisconsin Medical Journal*.

His committee appointments were published in the October Medical Forum section of the *Journal*. These appointments were announced at the conclusion of Doctor Griffith's address and on motion of Dr. J. W. Fons, Milwaukee, seconded by Dr. H. E. Kasten, Beloit, carried, they were approved.

REPORT OF DR. F. L. WESTON, TREASURER, FOR THE YEAR ENDED DECEMBER 31, 1951

This report, covering the year 1951, relates specifically to those parts of the Society's operations as are the direct responsibility of the treasurer. It includes, therefore, only the data for Membership and the Building Fund. The report consists of four exhibits, as follows:

Exhibit A—Comparative Financial Statements—Membership and Building Fund—December 31, 1951 and 1950.

Exhibit B—Summary of Membership and Building Fund Operations—1951.

Exhibit C—Statement of Membership Income and Expenditures—1951.

Exhibit D—Statement of Building Fund Income and Expenditures—1951.

Exhibit A

Comparative Financial Statements
Membership and Building Fund
December 31, 1951 and 1950

	December 31, 1951		December 31, 1950	
ASSETS				
Cash in Banks				
Treasurer's Account	$18,530.76		$15,970.14	
Special Cash Accounts	732.50		400.00	
Building Fund Account	5,307.16	$24,570.42	4,152.54	$20,522.68
Current Account—Wis. Physicians Service		66.59		
U.S. Treasury Bonds		14,240.63		14,240.63
Insurance Proceeds due from Aetna Life Ins. Co.				418.00
Working Capital Advances				
Wis. Physicians Service	$29,000.00		$29,000.00	
Wisconsin Veterans Medical Service Agency	7,500.00	$36,500.00	7,500.00	36,500.00
Building and Equipment				
Land	$16,616.10		$16,616.10	
Building	31,969.00		31,969.00	
Building Improvements	16,229.12		15,440.32	
Furniture and Equipment	9,625.82		8,932.74	
Total	$74,440.04		$72,958.16	
Less: Accumulated Depre.	8,804.10	65,635.94	5,485.99	67,472.17
Total Assets		**$141,013.58**		**$139,153.48**
LIABILITIES				
Advance Exhibit Space Rentals	$ 5,202.75		$ 4,846.25	
Dues Paid in Advance	332.50			
Total Liabilities		**$ 5,535.25**		**$ 4,846.25**
NET WORTH				
Membership Surplus	$136,035.23		$134,182.52	
Building Fund Surplus	(556.90)		124.71	
Total Net Worth		**$135,478.33**		**$134,307.23**

Exhibit B

Summary of Membership and Building Fund Operations—1951

Net Worth—January 1, 1951		$134,307.23
Membership Dues Income	$141,424.74	
Interest Received	392.15	
Total	$141,816.89	
Less: Membership Expenditures	139,964.18	
Excess—Income over Expenditures		$1,852.71
Building Fund Rental Income	$ 13,764.00	
Building Fund Expenditures	14,445.61	
Excess—Expenditures over Income		($ 681.61)
Increase in Net Worth		1,171.10
Net Worth—December 31, 1951		$135,478.33

Membership income and expenditures embrace all of the primary functions of the Society. Operations of the *Wisconsin Medical Journal*, Wisconsin Physicians Service, and Wisconsin Veterans Medical Service Agency are excluded, as are those of the Working Fund which relates to the

operation of the kitchen and lunchroom for employees and for meetings. The Building Fund covers operation and maintenance of the Society's headquarters building and the building services. Since rental income is determined annually at the beginning of the year on the basis of budgeted expenditures, actual operating results generally reflect a small gain or loss in the Building Fund.

Exhibit A compares the financial condition of these activities at the beginning and at the close of 1951. In Exhibit B is shown, in summary form, the manner in which 1951 operations accounted for the increase in net worth. Exhibits C and D show the results of these operations in greater detail.

Exhibit C

Statement of Membership Income and Expenditures—1951

INCOME			
Membership Dues Income		$141,424.74	
Interest Income		392.15	
Total Income			$141,816.89
EXPENDITURES			
Constitutional Officers and Committees		$ 36,840.50	
Organization—Staff		29,212.60	
Administrative Expense		24,389.08	
New Equipment		939.74	
Membership Special Service		4,403.81	
Wisconsin Plan		3,771.25	
Public, Industrial and Rural Health and Public Instruction	$30,205.05		
Less: Items of Income from these activities	585.60	29,619.45	
Annual Meeting, Teaching Clinics, and Wisconsin Medical Journal	$27,728.95		
Less: Items of Income from these activities	26,668.00	1,060.95	
Other Expenditures	$10,069.45		
Less: Item of Expense Reimbursement	342.65	9,726.80	
Total Expenditures			$139,964.18
Addition to Membership Surplus			$ 1,852.71

Exhibit D

Statement of Building Fund Income and Expenditures—1951

INCOME		
Rental Income	$13,764.00	
Total Income		$13,764.00
EXPENDITURES		
Wages	$ 4,252.50	
Telephone	1,715.42	
Insurance	636.66	
Heat, Gas, Light, and Water	1,564.35	
Repairs	390.96	
Supplies and Miscellaneous	807.46	
Payroll Taxes	140.46	
Property Taxes	1,070.10	
Depreciation	3,318.11	
Group Insurance	79.20	
Mail Services	470.39	
Total Expenditures		$14,445.61
Reduction of Building Fund Surplus		($ 681.61)

REPORT OF THE SECRETARY

The following report of the secretary was published in the Delegates Handbook:

Tradition, the Constitution, and By-Laws require the secretary to submit an annual report relative to administrative activities of the executive office. Obviously, it would be duplication to summarize those activities carried out under direction of various committees, which, in effect, are presented by the various committee reports themselves.

In the first six months of 1952, the staff attended 104 meetings, some of which were held on the same day, but on 23 occasions the meetings were of more than one day duration, such as that of the American Medical Association.

Staff attendance and staff participation, in so far as meetings of the State Society itself are concerned, mean the preparation of agendas, research activity, maintenance of minutes, and a multitude of details, which most physicians participating in the meetings would appreciate. It is a burdensome task occupying a great amount of time but one of the most essential responsibilities of the secretary's office.

Many meetings are arranged within the facilities of the home office which provides considerable relief from the transportation of file material, recording devices, and the like which are necessary when meetings are arranged in various hotels and communities throughout the state.

The secretary presents the following membership report as of August 31, 1952:

Affiliate members	61
Associate members	37
Honorary members	8
Life members	70
Military service members	79
Members in residency training	141
Total dues paying members	2,871
Total in compliance with all requirements	3,089
Total delinquent at date of this report	92

There are 17 members whose status is pending (including 10 members who paid county and state dues but have not remitted American Medical Association dues).
14 members are making partial payments.

It is worth emphasis to note that the By-Law requirement enacted in 1951, that all members of the State Medical Society of Wisconsin must also be members of the American Medical Association, has increased the total paying dues to the American Medical Association from 2,748 as of a comparable date in 1951 to 2,871. The requirement enacted by the House of Delegates in 1951 has not resulted in any substantial loss of membership to the State Medical Society. There are occasional instances when physicians have resigned or refused payment, and some delinquencies may be based on that circumstance; but on the other hand, there seems to be a general willingness to comply with the House action and a general understanding of its desirability that physicians present a united front.

It is not often that the secretary editorializes in any specific fashion in his report to the House of Delegates. As prior reports have been reviewed, since his first submitted in 1942, it can be said that their chief virtue has been in their brevity and in their summation of concise detail. However, the secretary feels it appropriate to comment on a distinct trend and one which is noticeable in his office.

Because of the development of Blue Shield of Wisconsin and the Veterans Agency, as well as other services to the membership, including the employment of a field secretary, total personnel now approximates 50 individuals; and it is anticipated that within the near future, developments within Blue Shield will require the addition of at least another five persons.

This points to the problems of administration not existent in 1940 when total personnel involved seven or eight individuals. The acquisition of a permanent office, the development of a Student Loan Fund, the offering of group disability insurance, increased activity in scientific meetings, and the expanding functions of the State Medical Society, as such and without regard to the programs of prepaid insurance and the home-town care of the veteran, are being handled by a secretarial and clerical staff of about 12 full-time individuals, a very small increase in personnel time compared with the tremendous increase in Society activities.

Still, the secretary is satisfied that the basic concept of the executive office is that of service to the physician. It is possible that such a concept can be lost; but the strength of the medical profession in its organization is dependent upon the emphasis given to scientific activities and membership service. But with the development of these manifold activities and the tremendous increase in detail which must be assumed within the secretary's office, there has come about a circumstance which, while anticipated, was not fully evaluated by the secretary.

Some doctors feel that it is the secretary's office which determines policy and when those policies do not coincide with the member's view, the result may be in any one of several fields,—passive acceptance, local criticism not directed to the secretary's office, or active resistance with resultant pressures of a personalized character.

In the first place, the secretary desires to emphasize that under the administrative policies of his office, together with the unmeasurable devotion of the Society committees, the Council, the Commission on Prepaid Plans, the Veterans Medical Service Agency, and the officers, he can reassure them, as well as the entire membership that there is no policy determination which has not been carefully studied, reviewed, and re-reviewed by active practicing physicians who are members of the State Medical Society.

The second point the secretary desires to make is his concept that the economic activities of the Society, and in particular its insurance programs, should not be the device by which the practice of individual physicians is guided, directed, or molded, into some common pattern. Decisions involving such fields, in the secretary's belief should be decisions arrived at by physicians meeting as members of their county medical society, as members of the House of Delegates of the State Medical Society, or as members of hospital staffs.

For example, it has been argued that the prepaid plans, in providing some specific benefit, should condition that benefit upon the service being performed pursuant to some formula. In a full analysis of the problem, it is found that physicians in their communities vary in the mechanism under which such a service is provided. To insist upon a pattern in the insurance plans would be to deny benefits to the subscriber when the physician himself did not conform to the pattern of the plans.

The secretary does not presume to argue the virtue of discussion upon numerous points that might illustrate the problem. He argues only that those problems constitute the responsibility of physicians and that no other concept should apply.

Thus, the secretary's office finds itself at times the object of pressures from within, while at all times the object of pressures from without, as the office endeavors constantly and consistently to represent the physicians under circumstances when physicians cannot represent themselves.

Only by constant reiteration of this point can the secretary feel that he has discharged his responsibility to the point that delegates, officers, and members can fully appreciate that if they are to continue in direction of the destiny of medicine, it is the physician of the state who must be active, responsible and interested.

It is distressing for one who serves an entire group to find himself at odds on occasion with some segment of it; but if the principle is correct, it cannot be compromised. The occasions have been relatively few, and to the secretary's deepest satisfaction, the validity of the policy just enunciated has ultimately been fully recognized.

In 1951, the secretary reported to the House of Delegates at the time inquiry was made as to the operating budget of the State Medical Society, that his salary was entirely assigned to the dues account, and in no manner directly or indirectly allocated to specific operating ventures of the Society.

He reported to the House of Delegates that such action had followed upon his own request, for it is his firm conviction that no one who represents physicians in their entirety should derive compensation from any specialized phase of their activity. Secretaries possess all the weaknesses common to mankind, and it would follow as the night the day that to do otherwise inevitably would affect the impartiality of his judgment.

The secretary possesses the same admiration and firm devotion to the profession of medicine as he does for his own profession. He is as proud of the one as of the other. He feels as much a part of the first as he is part of the latter.

With comprehensive and sometimes significant understanding by physicians of all that transpires within the profession of medicine today he feels that he can report in optimistic appraisal of the future that the profession of medicine will survive those who would regiment it. The health of the people will be served by their personal physicians rather than those who are under direction of governmental bureaucracy and all that it implies.

In supplementary remarks, Mr. Crownhart made the following statements:

It is with some considerable pride that I can tell you of the effectiveness of your executive staff and the others who work with us, and the fact that those men, much like yourselves in your professional activity, have set for themselves standards beyond the call of duty.

Working for the State Medical Society of Wisconsin presents some rather unusual problems at times. Certainly the hours are somewhat unusual, and we are frank to admit that even your staff is subject to night calls.

I am proud of the staff, and you should be proud of them. They are your working instrumentality. They could pay lip service to the duty and to the salary, but I am sure you can appreciate from the evidence of their work that they are giving you their wholehearted devotion.

More than that, however, is the realization that comes to me from time to time, that one can expect physicians to arise to the occasion. I must confess that participation in committee meetings, meeting with the councilors and the officers, and the trials and tribulations of prepaid insurance not infrequently give us cause for very considerable concern, because we think we see a total picture, and we are afraid we did not assemble the facts and get them before the doctors.

However, in the pinch the doctors always come through. One of the most notable occasions of that was the very tremendous effort given by Doctor Arveson in preparation for his appearance before the Minneapolis hearing of the President's Commission on the Health of the Nation. It is not an easy thing to stand before a large group of people when there has been a series of critical, unevaluated, and sometimes quite personal comments about the medical profession, and then with dignity and sincerity be able to present the views as did Doctor Arveson and, I would like to say, as did Doctor Kennedy, of the Minnesota State Medical Association.

There are so many within the medical profession that I should like to compliment, people such as Doctor Dessloch, who has given hours of his time to prepaid insurance —and the members of the Council on Scientific Work, who meet so often and in long, grueling sessions to prepare your program.

I mention these several things briefly because I feel that there must come to the House, from time to time, a keener appreciation of the work done by these men who have been designated to represent medicine before the public and in public places.

There is no hierarchy in the State Medical Society except of one group and of one group only, and that is the physicians who, beside serving their patients in their personal needs, are willing to serve your patients collectively and present your views as you see them.

Statistically, we account now for 3,205 members in the State Medical Society. When I first appeared before you following my brother's death in 1941, we were reporting to you concerning a total number of 2,440 members in the State Medical Society. That growth of nearly 800 members in 12 years' time is an indication in itself of the extent to which the medical profession has increased in size in Wisconsin. Of the total number of 3,205, 2,890 of them are full dues-paying members.

Finally, since the report of those members and physicians, who have died in Wisconsin, was submitted by the state office, we report the deaths of the following physicians. (Members are indicated by bold type.)

E. F. Cook, Milwaukee
D. G. Hugo, Oshkosh
A. A. Krygier, Milwaukee
W. L. LeCron, Milwaukee
W. A. Meilicke, West Bend
Paul E. Pifer, Kenosha

C. A. Vogel, Elroy
B. H. Warren, Janesville
C. H. E. Wheeler, Platteville
J. M. Kelley, Manitowoc

The House rose in silent tribute to these deceased physicians.

INTRODUCTION OF GUESTS

Speaker Tenney introduced the following guests to the House of Delegates:

Dr. Roger Kennedy, president of the Minnesota State Medical Association.

Dr. A. O. Swenson, chairman of the Council of the Minnesota Association.

Dr. O. J. Campbell, president-elect of the Minnesota Association.

Dr. Frank Elias, past president of the Minnesota Association and its American Medical Association delegate.

Mr. R. R. Rosell, executive secretary of the Minnesota Association.

Doctor Kennedy, in addressing the House of Delegates briefly, made the following remarks: Mr. Speaker and members of the House: The most pleasant duty that has come to me during my term of office has been to accept this cordial invitation from your officers to share in the representation of the Minnesota State Medical Association at your Annual Meeting.

In extending greetings from the Minnesota State Medical Association I know that my colleagues who are here, and all the officers and members of the Minnesota State Medical Association, value immensely the splendid spirit of friendship and cooperation that exists and that has existed between our respective Councils and executive officers.

May I express the hope that these cordial relationships will continue to be fostered and nurtured, to the end that this area of the North-Central Midwest will be recognized for its eminent position in strengthening the standards of medical practice and of community health.

I cannot help but recall the remarks of your able and kind president upon the occasion of the visit of your officers to the last session of the Minnesota State Medical Association. They commented on how consoling it is to have the opportunity to visit a neighbor group, to see that they have the same problems to struggle with, and that they enjoy the same sense of success or, let us say, the same feeling of disappointment when they find that the problems are almost greater than they can cope with.

The close rapport between our respective executive officers is worthy of special comment. In Minnesota, as many of you know, we have as executive officer, Mr. Rosell, known to many of you for his bald pate and for his great length and breadth of wisdom. He has made many suggestions which have been incorporated into the organization and operation of the Minnesota State Medical Association.

Those of us in Minnesota, who have been endowed with an inquisitive turn of mind, when we examine closely into the origin of his many brilliant contributions, find almost invariably that they originated in the minds of Mr. Crownhart or Mr. Ragatz. (Laughter) Fortunately for us in Minnesota, the St. Croix River is not a barrier to the westward migration of good and useful ideas.

On behalf of the Minnesota State Medical Association, Mrs. Kennedy and I thank you wholeheartedly, and we all wish for you a successful and fruitful administrative and scientific session. May I extend to each and every one of you a cordial invitation to take part with us next year in celebrating the 100th anniversary of the Minnesota State Medical Association.

EXCERPTS FROM REPORT OF STATE HEALTH OFFICER

DR. C. N. NEUPERT: For a number of years now it has been my privilege to come before you each year at your annual session. It is not a concession on my part—it is a privilege. It is not a matter of personal privilege, of course; in my judgment it really indicates that the physicians of this state have a genuine interest in all the aspects of health,—the preventive as well as the curative, official as well as voluntary. My appearance here, then, is in recognition of that official agency, the State Board of Health.

We keep in touch by working together rather effectively. I have heard some compliments of our current issue of HEALTH, the bi-monthly bulletin. Your officers and your leaders wrote it.

Right now, we are attacking the matter of infant and maternal death causes. The report of your own committee has to do with that, and I would like to congratulate your Committee on Maternal and Child Welfare. In 1952, out of nearly 88,000 births there were only 42 maternal deaths, and now the committee is going into a study of the neonatal and fetal death problem.

As of June 30, 1953, the Board of Health will withdraw from cooperative arrangements with eight cities in which there are state cooperative laboratories now in operation. In early 1953, the new laboratory at Madison will be opened and it will be ready to take on the water analysis problem. It will do whatever it can in the way of specimen examinations that these other city laboratories will be unable to handle. Most cities probably will continue to operate their laboratories. We will help them all we can.

Deaths from heart disease, cancer, and accidents will not come down too much until the people, your patients, are more aware of the early signs, and then do something about them. I am speaking now about health education. You, as a Society, are doing an excellent job in the March of Medicine radio program, where 32 state stations and one in Michigan and one in Minnesota are carrying the program every week. You are also doing a very special job in rural health and now with the Conference on Physicians and Schools.

In the State Board of Health we appreciate the privilege of working with you. We could not discharge our responsibilities without your support and cooperation.

EXCERPTS FROM ADDRESS OF THE PRESIDENT OF THE WOMAN'S AUXILIARY

MRS. R. M. KURTEN, *Racine:* The past two years have given me an excellent opportunity to clarify my own thinking about Medical Society–Auxiliary relationships on both state and county levels. I have visited many county auxiliaries, and have been given frank opinions on the value of the Auxiliary as an organization and particularly as an auxiliary to the county society.

There are those who tolerate, belittle, ignore, show hostility, or say, "I don't want my wife to belong to that organization."

On the other hand, there are those who realize the potential for better understanding between the public and the profession when the two organizations work together on both state and county levels. All we (the Auxiliary) need, in my opinion, to be a truly going concern, is to have intelligent, tactful supervision and criticism from State and county societies.

I say with deep conviction that all the Whitakers and Baxters in the world cannot do what you and your intelligent and deeply concerned wives can do if properly encouraged.

My request to the Council for additional secretarial help was immediately granted last November. We have had from the executive office in Madison the utmost in encouragement, aid, and assistance.

There are 52 county societies in Wisconsin; there are 26 auxiliaries. I have found many auxiliaries whose enthusiasm is boundless. In many instances, this has been due to the nurse recruitment program, which has been brought about by the hard work of the officers of this organization, particularly the immediate past-president, Mrs. J. S. Huebner, and Mrs. Victor Falk as chairmen in the nurse recruitment program.

If we could have representation in the State Medical Society in those branches of activity where we could be truly effective, followed by the same program on the county level, there would be in Wisconsin the same enthusiasm that is evident in states where such a program maintains.

Activities which go on continually are blood banks, Red Cross, health service cards printed and distributed to newcomers in the community, promotion of "Today's Health", loan closets, organization of, or membership in, public health councils, and so on.

In 1953, the Auxiliary will celebrate 25 years of organization. The wives of young doctors are, in most instances, keenly aware of their responsibilities, and I believe that if some of the ills of modern medicine were studied by the wives of the men who are causing them, there would be some lessening of the contagion.

The Auxiliary proposes that it have officially:

1. Recognition of itself as an ally.
2. Appreciation of the Auxiliary program so that men will not say, "I don't want my wife to belong."
3. Cooperation in periodic meetings and joint planning on both state and county levels.
4. Coordination with projects undertaken.
5. Faith in our ability to do the jobs that need to be done.

EXCERPTS FROM REPORT ON STUDENT LOAN FUND

DR. H. H. CHRISTOFFERSON, *Colby:* When I appeared before the general assembly as president of the State Society, I called your attention to the high cost of medical education. I made the statement that only a doctor's son or a millionaire's son could become a doctor, and for that reason we might well interest ourselves in a Student Loan Fund. I believe that we should go into the rural areas and pick young men out of the small high schools, and interest them in the study of medicine. The reason for this is that there is actually a shortage of physicians in many, many rural areas, and these boys would be much more likely to go back into the rural areas.

I have long advocated that the doctors should club together and start to practice medicine in the rural areas in groups of two or more. I believe that many communities would assist young doctors in buying the equipment necessary to render first-class medical service.

The Student Loan Fund should be used to assist the poor boy in getting his medical education. The banks of this state are watching the doctors, waiting to see if we really meant what we said,—that we would create a Student Loan Fund. I am informed that bankers and industry will contribute liberally to such a movement if we raise about $40,000 or $50,000 among the doctors.

It is one of the sacred obligations of our profession to help these men in their plight. A good many of our medical students today are only a few dollars from being broke. Some fear that it will mean the end of their medical training. I am convinced that many good students from small cities could be induced to go to medical school if they had the security of a Medical Society Loan Fund behind them when it was needed. I know of no greater contribution that we could make to the progress of medicine in this state than to be ready to aid needy and deserving medical students. This would not be a gift; it would definitely be a loan and must be repaid when the student is able to do so. In that way, in years to come it will become a revolving fund.

I urge you to support this program very seriously. Ten or fifteen thousand dollars have already been raised. Let us boost that to forty or fifty thousand dollars, and then go to the bankers and to industry and ask them for their support, to help raise $250,000 that has been set by the Board of Trustees of the Fund as its goal.

REFERENCE OF REPORTS

Speaker Tenney announced referral of reports to the following committees:

To the Reference Committee on Reports of Officers: Report of the President, Report of the President-elect, Report of the Treasurer, Report of the Secretary, Report of the AMA delegates, and Report of the Auxiliary.

To the Reference Committee on Reports of Standing Committees: Committees on Cancer, Care of Crippled Children, Goiter, Grievances, Hearing Defects, Hospital Relations, Maternal and Child Welfare, Mental Hygiene, Institutional Care, Public Welfare and State Departments, Public Policy, Scientific Work, Tuberculosis and Chest Diseases, and Visual Defects.

To the Reference Committee on Resolutions and Amendments to the Constitution and By-Laws: Report of the Council, Report of Commission on Prepaid Plans, Report on the Student Loan Fund, Report of the Council on Medical Service, and Dues for 1953.

Speaker Tenney stated that it is a privilege, as well as an opportunity, for any interested member of the Society to appear before these committees and present his views on any matter properly before them.

Announcement was made of the time and place of reference committee meetings on Monday morning.

COMMITTEE ON NOMINATIONS SELECTED

Following a councilor district caucus, on motion of Dr. A. M. Christofferson, Waupaca, seconded by Dr. G. W. Carlson, Appleton, carried, the following delegates were approved as members of the Nominating Committee:

District	*Nominee*
1	C. J. Garding, Jefferson
2	E. J. Schneller, Racine
3	J. H. Houghton, Wisconsin Dells
4	D. H. Hinke, Richland Center
5	E. C. Cary, Reedsville
6	H. J. Kief, Fond du Lac
7	T. E. Gundersen, La Crosse
8	C. E. Koepp, Marinette
9	A. M. Christofferson, Waupaca
10	W. C. Henske, Chippewa Falls
11	J. W. Prentice, Ashland (Charles W. Giesen, Superior, alternate)
12	J. A. Enright, Milwaukee
13	C. E. Zellmer, Antigo

ADJOURNMENT

The first session of the House of Delegates adjourned at 5:10 p.m.

SECOND SESSION

Monday, October 6, 1952

The second session of the House of Delegates convened at 6:50 p.m., Dr. H. Kent Tenney, Speaker of the House, presiding.

REPORT OF COMMITTEE ON CREDENTIALS

The Committee on Credentials verified the registration of 61 delegates and seven alternate delegates entitled to vote at this session of the House of Delegates. In addition, 12 alternate delegates, 10 councilors, and three past presidents registered their attendance.

On motion of Drs. T. J. Aylward, Milwaukee, seconded by E. C. Cary, Reedsville, carried, the attendance roll of delegates and alternate delegates totaling 68 was accepted as the official roll of this session of the House.

Report of Reference Committees

REPORT OF REFERENCE COMMITTEE ON REPORTS OF OFFICERS

This reference committee, composed of Drs. L. O. Simenstad, Osceola, chairman; J. W. Fons, Milwaukee; M. W. Stuessy, Brodhead; D. N. Goldstein, Kenosha; and P. B. Mason, Sheboygan, presented the following report.

Report of the President

The reference committee felt that an outstanding program has been developed as the result of President Heidner's recommendations before the House of Delegates last year. That program has been known as the Medical-Press Conference, six of which have been held throughout the state during the past year. Radio people, newspaper men, physicians, and others were invited to discuss mutual problems, and almost 600 people were thereby brought together to present their thoughts on matters of advertising, obtaining information relative to a patient's condition from hospitals and physicians, and ethical problems involved in the release of information to the press and radio.

The reference committee was of the opinion that not only should these conferences be continued, but they should be expanded to other areas in the state.

The reference committee also commended President Heidner for his untiring efforts in attending meetings of Society commitees, as well as many meetings held in other states. The office of president is demanding, and President Heidner has filled it well.

On motion of Doctor Simenstad, seconded by Dr. J. W. Fons, Milwaukee, carried, this section of the report was accepted.

Report of the President-Elect

In Doctor Griffith's report, he urged extension of insurance benefits and broadened coverage under voluntary principles. The reference committee felt that the president-elect's recommendation of consideration of catastrophic insurance was essential, and that health insurance must be expanded to the rural areas through more vigorous sales efforts and promotion.

Doctor Griffith's review of expenditures in the health field by public agencies was most revealing. The committee felt that more local control should be achieved in the disbursement of these funds, and that, whenever possible, committees of the State Medical Society should urge that these funds be channeled through local government, rather than national. If the newly proposed Council on State Departments were approved by this House of Delegates, it could undoubtedly be helpful in this respect.

The reference committee urged that every delegate give full consideration to the president-elect's statements relative to the political party platforms, so that he is apprised of the views of the candidates before he exercises his right to vote.

Finally, the reference committee commended the president-elect for his report on the relationship between the medical profession and Selective Service, and reiterated his commendation of the work done by Doctor Weston and his Committee on Military Medical Service.

On motion of Doctor Simenstad, seconded by Dr. T. J. Aylward, Milwaukee, carried, this portion of the report was accepted.

Report of the Treasurer

The reference committee was impressed with the concise report submitted by Doctor Weston, and commended him on the manner in which the financial status of the Society was presented to this House of Delegates. Many hours of work are devoted by the treasurer to his office during the year, and his performance of duty has been outstanding. The reference committee felt that the Society's finances are in excellent hands.

On motion of Doctor Simenstad, seconded by Dr. T. A. Leonard, Madison, carried, this section of the report was accepted.

Report of the Secretary

The reference committee called attention to the fact that during the first six months of 1952 the staff attended 104 meetings. It is hoped that this number could be reduced in the next year if the Council on State Departments proposal were adopted

The reference committee also emphasized the secretary's statement that no policy determination is made in the Society's office, but that through study, review, and re-review of matters by Society committees, the Council, the Commission on Prepaid Plans, the Veterans Agency, and officers, such determinations are made.

The secretary and his staff were commended for the great amount of time and energy devoted to the affairs of the medical profession in this state.

On motion of Doctor Simenstad, seconded by Dr. J. W. Fons, Milwaukee, carried, this section of the report was accepted.

Report of the American Medical Association Delegates

This report was mailed to every member of the Society following the December and June sessions in Los Angeles and Chicago. The reference committee felt that the Society is indeed fortunate to have such excellent delegate representation in the parent organization. Their opinions are sought and respected by the AMA House, and their reports back have been comprehensive and most informative.

On motion of Doctor Simenstad, seconded by Dr. O. O. Meyer, Madison, this section of the report was accepted.

Report of the Woman's Auxiliary

Mrs. Kurten had stressed the need for closer liaison between the Society and its Auxiliary, as well as a greater understanding of the problems with which the physicians are faced. These women are anxious to be of assistance in committee activity and public relations efforts, but many times they are unable to do so because they do not know what problems exist, or they have only a vague knowledge that they do exist.

The reference committee felt that a real service can be rendered the Society through its Auxiliary; and to accomplish this cooperative effort it recommended that the president of the Auxiliary be sent notices of committee meetings in which the Auxiliary would be interested and could be of material assistance in developing projects discussed. She would then be able to attend, or delegate this duty to one of her committee chairmen, who would subsequently relate pertinent information to the county auxiliaries.

Physicians are urged to encourage their wives to become active Auxiliary members. The reference committee felt that with this encouragement many wives, who are not now members, will take a real interest in the projects which the Auxiliary is undertaking, all of which will bring about a closer liaison and understanding.

Further, in areas where auxiliaries do not now exist, physicians are asked to encourage their wives to form them. The reference committee also felt that at least once a year county societies should arrange joint meetings of physicians and their wives, perhaps providing a speaker of interest to both groups and a program of mutual concern.

On motion of Doctor Simenstad, seconded by Dr. J. W. Fons, Milwaukee, carried, this section of the report was accepted.

On motion of Doctor Simenstad, seconded by Dr. D. N. Goldstein, Kenosha, carried, the report, as a whole, was adopted.

INVITATION TO A.M.A. MEETING

President Heidner was granted the privilege of the floor to read the following telegraphic message from Edward J. McCormick, M.D., president-elect of the American Medical Association:

> "On behalf of Dr. Louis H. Bauer, who is currently out of the country, I would like to officially invite all members of the State Medical Society of Wisconsin to the American Medical Association's Sixth Annual Clinical Session. This year's meeting, to be held in Denver, Colorado, December 2 to 5, promises to be of exceptional interest to all doctors of medicine."

REPORT OF REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES

The following committee reports, published in the Delegates Handbook, were considered by this reference committee, composed of Drs. G. W. Carlson, Appleton, chairman; Marvin Wright, Rhinelander; E. R. Daniels, Milwaukee; A. T. Smedal, Stoughton; and K. H. Doege, Marshfield. Its recommendations and House action are noted.

Committee on Cancer

A. R. Curreri, chairman; W. S. Bump; L. J. Van Hecke; D. C. Beebe; S. L. Henke; A. C. Taylor; R. P. Welbourne; P. B. Blanchard; W. E. Bargholtz; G. L. McCormick; K. G. Pinegar; J. W. Conklin; G. C. Schulte

For the past several years the reports of this committee have stressed the need for more professional interest in the early detection of cancer and recognition on the part of the individual physician that the best possible cancer detection center is in his examining room.

This past year further efforts have been made on the part of the Committee on Cancer to make the public appreciative of what can rightly be expected of a physical examination, with special attention directed to the detection of carcinoma. The committee has accepted the views of the medical profession in Wisconsin that outside of highly urbanized areas the formal establishment of a cancer detection center is not the most practical approach to the problem of cancer control. It has approved of the thesis that the individual physician is prepared to detect cancer early in his patients through a thoughtful examination and history.

To direct the thinking of the public along these lines a simple leaflet entitled "Things You Should Understand if You Want a 'Cancer Examination'" was prepared and distributed widely through doctors' offices and at public meetings. To date more than 600 Wisconsin physicians have requested quantity orders of this leaflet and have distributed it through their waiting rooms, in their statements, and through other means. More than 116,000 leaflets (out of a total of 138,000) have been distributed by Wisconsin physicians to date, and the demand is still brisk. All physicians are urged to make use of this pamphlet, and to assume the responsibility of providing a satisfying experience for those patients who seek advice concerning the possibility of cancer, even though they can be clinically classified as "well patients." Cancer control can never attain its objective of saving lives through early detection if physicians brush aside the concern of well patients and discourage them from seeking periodic health evaluations.

The Committee on Cancer, serving as the Medical and Scientific Committee of the Wisconsin Division of the American Cancer Society, has reviewed special research programs at McArdle Memorial Cancer Institute and the operation of the Upper Peninsula Cytology Laboratory at Menomonie, Michigan, which serves a large Wisconsin area. Direct support in the form of financial aid from funds of the Wisconsin Division has been allocated for these important projects.

The American Cancer Society is conducting a five year research project to determine the smoking habits of white males in the age group of 50 to 69, and to determine if possible whether there is any relationship between smoking and lung cancer. The project has been reviewed by the Committee on Cancer this past year, and authority was granted to conduct such a survey in Wisconsin.

While the presentation of special "Cancer Clinics" of postgraduate teaching has been discontinued, and support granted the over-all teaching program of the State Medical Society, efforts are being made to have hospital staff conferences devoted to fundamental review of technics and practices in the effective early detection of cancer. Hospital staffs will be contacted, offering speakers from the two medical schools as well as private practitioners closely identified with the cancer program, to direct more attention of hospital staffs to opportunities of early detection through proper examination and laboratory technics. It is hoped that during the ensuing year many hospital staffs will avail themselves of this opportunity.

The Committee on Cancer has given its support to the continued postgraduate educational program of the State Medical Society by securing from the Wisconsin Division of the American Cancer Society direct support for the general postgraduate teaching program and the underwriting of the cost of an outstanding speaker for the 1952 Annual Meeting program.

Recommendations

(1) That individual physicians continue their contacts with the cancer control program in Wisconsin by making the slogan of "every doctor's office is a cancer detection center" one which will have real meaning in terms of sound medical practice and satisfaction of patients seeking examinations on a periodic basis. That in establishing a patient understanding of what can and cannot be expected of a "cancer examination" the essential procedures be carried out at a cost which will encourage periodic health evaluation on the part of the patient and still provide the physician with a reasonable return for the time and effort taken to render the service.

(2) That physicians make even greater use of the pamphlet, "Things You Should Understand if You Want a 'Cancer Examination,'" so that a better appreciation of cancer control can be attained by the general public.

(3) That hospital staffs direct special attention to cancer through at least one staff meeting per year, at which time significant cases can be reviewed and special speakers provided through the Wisconsin Division of the American Cancer Society.

The reference committee recommended that individual physicians continue their contacts with the cancer control program and encourage periodic health examinations; secondly, that greater use be made of the pamphlet, "Things You Should Understand If You Want A Cancer Examination"; thirdly, that hospital staffs direct special attention to cancer through at least one staff meeting each year.

On motion of Doctor Carlson, seconded by Dr. O. O. Meyer, Madison, carried, this section of the report was accepted.

Advisory Committee on the Care of Crippled Children

H. A. Sincock, chairman; A. B. Schwartz; C. M. Kurtz; W. P. Blount; C. M. Ihle; R. E. Housner

One meeting of this committee is held annually, unless some special problem arises which necessitates extra meetings. With the Bureau of Handicapped Children enjoying competent medical direction, there is little need to have the Advisory Committee concern itself with minor matters of administration or policy.

The reviewing of the entire program of the Bureau of Handicapped Children indicates a steady growth of services and a continuation of the basic policy of the Bureau that it is prepared to meet needs which cannot be met through the utilization of local resources, but that whenever possible the participation of the individual served and the local community, by way of part or full payment, is encouraged. The Bureau continues to make itself available to set up demonstrations of services which should be made available to meet the needs of the handicapped child, and then to encourage community support of such projects.

The Orthopedic Program: In 1951, 38 separate clinics were held, upon request of the county medical societies, with 2,129 children being served, of whom 518 were entirely new cases and 1,611 examined for re-evaluation and determination of progress made in therapy. It has been reported that there are now 34 qualified orthopedists available for service, and all except about six have accepted the responsibility of conducting clinics upon call by the county medical society requesting the service.

Nearly 50 per cent of the cases are those associated with poliomyelitis, and the majority of other cases involve foot deformities, spastic cases, and congenital deformities of the feet and legs.

Polio: As indicated, the orthopedic program is particularly concerned with the therapy provided the patient who has had poliomyelitis. It is the feeling of those most closely associated with the medical aspects of the Bureau of Handicapped Children that there is still a disturbing tendency in many localities to protract hospitalization long beyond the period of benefit to the patient. In a few Wisconsin hospitals the physiotherapy program is sufficiently developed so that continued hospitalization is of definite benefit to the patient. In most hospitals this is not so, and the resulting period of hospitalization without specific benefits of medically supervised physiotherapy is retarding rehabilitation and placing the patient at a disadvantage in attaining the optimum benefits of recovery.

It is felt that such undesirable practices are resulting in a great loss of funds donated by the public for the care of polio patients which should be utilized in other and more effective ways. Of more importance, they are lessening the opportunities for early recovery on the part of the patient and increasing the difficulties of subsequent therapy.

The family physician is the one who can do most to correct this situation by insisting upon a proper evaluation of the patient's situation as soon as the acute phases of the disease have subsided. All physicians have been supplied with a list of qualified orthopedists who have signified their willingness to serve as consultants, and if such a consultation service cannot be paid by the family without undue hardship, there are funds available, through the local chapters of the National Foundation for Infantile Paralysis, to provide financial support for this important service. The Advisory Committee urges that every doctor confronted with the care of the polio patient insist upon such an evaluation and consultation early during the hospitalization, and a subsequent re-evaluation prior to the time when the patient is released from the hospital, so that state agencies prepared to assist with rehabilitation and occupational therapy can assist the patient before serious physical and psychic disturbances arise due to neglect of maximum therapy.

Cerebral Palsy: There is still much to be done in this field, but some important new developments have been brought to the attention of the committee which will be of great service to physicians confronted with cerebral palsy patients. Through the cooperation of the Wisconsin Society for the Disabled and the University of Wisconsin Medical School a special cerebral palsy research and study project has been developed at Wisconsin General Hospital, which will operate on an out-patient basis. This will provide an avenue for intensive study and evaluation of cerebral palsy in small children, so as to provide a more scientific basis for therapy and education. The Bureau of Handicapped Children is also cooperating in the development of this special research and teaching program. In addition, special clinics for children and parents have been maintained in Racine and Fond du Lac during 1951, both being organized by parent groups and conducted on a strict referral basis. These programs have been encouraged by the Bureau of Handicapped Children, and financial assistance provided when needed, though the cost of appliances has been provided locally through a brace fund sponsored by the parents' groups.

Defective Speech: It is estimated by the Bureau of Handicapped Children that there are approximately 8,000 children in Wisconsin who are receiving services in the defective speech program. Through the work of 69 speech correctionists most of the large urbanized centers in the state have special services for residents of the area. In addition, there are special speech courses at the University of Wisconsin during the summer session, both for children with cleft palates and for those with marked retardation records (excluding those with I.Q. levels below 70 and those who are classified as deaf) and a plastic clinic at the University of Wisconsin Medical School, with special follow-up attention given to the cleft palate and cleft lip deformities.

Acoustically Handicapped: The complete report on this service is reviewed in the report of the Committee on Hearing Defects. In reviewing this phase of the program the Advisory Committee was impressed with the completeness of the coverage and the extent to which rechecks are being conducted to make the service realistic and not merely a statistical survey.

Visually Handicapped: The details of this portion of the program of the Bureau of Handicapped Children are presented in the report of the Committee on Visual Defects.

Mentally Handicapped: Individual psychometric studies are made available for any child upon request. At each orthopedic clinic a clinical psychologist is present for consultation. In 1951 approximately 500 psychometric evaluations were made by the supervisor of special classes and the psychologist on the staff of the Bureau of Handicapped Children.

The Bureau reported to the Advisory Committee that there are 178 special classes for the mentally handicapped in Wisconsin. In the school year 1950–51 there were 3,544 children enrolled in these special classes.

Funds have been appropriated by the Wisconsin Legislature for the establishment of classes for children having an I.Q. of 35 to 50, who were formerly thought to be uneducable. Two such classes have been formed, in Eau Claire and Milwaukee, and five additional ones are being planned.

Rheumatic Fever Program: The Advisory Committee was provided with an interesting report of an experiment being carried out at St. Mary's Hospital, Madison, with home care directed by Visiting Nurses Association personnel. If this experiment proves satisfactory, it should modify any further development of separate convalescent homes and materially reduce the costs of care.

The report also made note of the fact that convalescent care involves the use of rather expensive drugs over a long period of time, and that in the opinion of pediatricians and cardiologists, who have been in close contact with the operation of the convalescent home in Madison, such use of drugs is justified and has resulted in a much lower incidence of repeat cases.

* * *

In addition to the various programs conducted by the Bureau of Handicapped Children, the Advisory Committee received a more complete report on the Cerebral Palsy Center from representatives of the Wisconsin Society for the Disabled and from the physician at Wisconsin General Hospital who is most closely associated with the project. The development of this program meets with the hearty approval of the Advisory Committee, and it suggests that the research facilities of the project be used by physicians confronted with special problems related to cerebral palsied patients, particularly young children.

At the same meeting the Advisory Committee was informed by a representative of the State Board of Health that a special pamphlet on polio was being developed for lay consumption. This pamphlet, entitled "Story of Polio," was reviewed and approved. It has since been distributed to all physicians in the state.

Recommendations

(1) That physicians establish a closer relationship with the operation of the orthopedic clinics, and, when possible in the evaluation of new cases, personally accompany the child and his parents to the clinic and derive the benefits of consultation with the orthopedic specialist in attendance.

(2) That in the care of polio patients each physician accept the recommendations of the Advisory Committee in seeking consultation with a qualified orthopedic specialist, selected by the family upon advice of the attending physician, to properly evaluate the physical condition of the patient after the acute phase of the disease has subsided and to determine the extent of involvement and the extent to which continued hospitalization will be of direct benefit to the patient. Also, if hospitalization is extended, that specialized consultation be secured at reasonable intervals to re-evaluate the case, and when in the opinion of the consultant hospitalization is of no further value in therapy,

that a meeting of the family physician, the consultant, and representatives of state agencies prepared to assist in rehabilitation be held to chart a course of home care and therapy, with the aim of securing maximum recovery of the patient and preparing him for independent economic life, with or without a handicap.

(3) That the larger county medical societies set up committees to study the care of rheumatic fever patients and derive the benefit of current studies of the Bureau of Handicapped Children in respect to home care under proper nursing supervision.

(4) That professional support be given the Cerebral Palsy Clinic at Wisconsin General Hospital so that cases of real significance can be provided for research and teaching, as a means of charting the course of diagnosis and therapy for patients at an early age.

The reference committee recommended adoption of these recommendations and commended the Advisory Committee on Care of Crippled Children for its fine report.

On motion of Doctor Carlson, seconded by Dr. J. W. Fons, Milwaukee, carried, this section of the report was accepted.

Committee on Goiter

A. S. Jackson, chairman; T. J. Pendergast; B. J. Peters; O. E. Satter; C. N. Neupert; E. S. Gordon

As indicated in the 1951 report to the House of Delegates, this committee has not been active, inasmuch as the present program of goiter control seems to be progressing satisfactorily through active cooperation of school authorities and public health nurses.

It is pleasing to report that during the past year the Catholic parochial schools have taken a more active part in the program and in many localities steps have been taken to provide protection for students by the use of iodine tablets.

While the coverage in elementary schools is commendably high, the committee has noted a tendency in many communities to discontinue the protective program at the conclusion of the elementary grades. The committee wishes to re-emphasize the point made in previous reports that the use of iodine tablets is highly desirable throughout the period of physical growth, *including the high-school years.*

The continued cooperation of county boards, school officials, and public health nurses has resulted in a state-wide program of such general acceptance that there is little need for the committee to function actively.

The reference committee recommended acceptance of the report; and on motion of Doctor Carlson, seconded by Dr. J. W. Fons, Milwaukee, carried, this section of the report was accepted.

Committee on Grievances

R. E. Fitzgerald, chairman; E. W. Mason; F. A. Nause, C. E. Zellmer; E. D. Sorenson; H. W. Wirka

During the past year, the committee has held six formal meetings, and has instructed the secretary's office to conduct various studies and inquiries on matters brought to its attention. In addition, individual members of the committee have consulted with staff members between formal meetings.

As pointed out by Dr. A. H. Heidner in his President's Page appearing in the February Wisconsin Medical Journal, the Grievance Committee has no jurisdiction over matters before it. It can and does weed out cases due to misunderstanding, personal quarrels and ill-advised interference, and uncalled for advice from relatives and so-called friends.

Whenever a case is settled through sensible, reasonable discussion and explanation of facts, everyone is benefited.

During the past year, the committee met with the Committee on Interprofessional and Business Relations of the Wisconsin Bar Association for a discussion of problems arising when doctors are called as witnesses in lawsuits and other matters of mutual concern. As a result of this meeting, a Steering Committee on Medical-Legal Problems was appointed composed of representatives of both groups. It will prepare statements or principles outlining the proper relationship between the lawyer and doctor, and their responsibilities in testifying and in securing reports concerning treatment, examination, and opinion relative to an individual's condition.

The Grievance Committee has also authorized a joint meeting with representatives of the Wisconsin Hospital Association for a discussion of patient problems and hospital-physician relations. When this meeting is held, cases involving hospitals will be discussed in an effort to bring about a better understanding of mutual problems.

The committee is of the opinion that it has served to satisfy many misunderstandings. Its work and its records are maintained in complete confidence.

The reference committee recommended acceptance of this report, and on motion of Doctor Carlson, seconded by Dr. J. W. Fons, Milwaukee, carried, this section of the report was accepted.

Committee on Hearing Defects

T. L. Tolan, chairman; W. C. Randolph; G. B. Ridout; J. A. Hurlbut; J. W. Tanner

In past reports of this committee attention was directed to the outstanding hearing program being developed by the Bureau of Handicapped Children and the desirability of having each physician well acquainted with the basic procedures followed, as approved by the Committee on Hearing Defects.

Since the last report the entire state program has been combined under the direction of the Bureau of Handicapped Children, including the experimental program formerly conducted in the Eighth Public Health District by the State Board of Health.

A review of the 1951 program shows that at the end of the year only 10 counties were without a hearing program, and since that time all of these areas have started a program with the Bureau of Handicapped Children.

During 1951, 34 counties were served by the program, with around 150,000 children screened, and 2,214 examined at 45 otologic clinics, served by 25 otologists.

Now that the entire state has been, or will be, covered with a periodic screening program, steps are being taken to establish local programs so that in the 25 "primary centers," where speech correctionists are available, half of the children will be examined each year. Efforts are being made to have local programs set up on a three year basis, with the same otologist used each of the three years, so that continuity can be achieved.

The Committee on Hearing Defects continues to be impressed with the intelligent leadership given this program by Dr. Maxine Bennett, medical director, Mr. Frank Powell, director of the Bureau of Handicapped Children, and their well trained staff. The philosophy of self-help and the full utilization of local resources, rather than encouraging dependency upon state help, is one which should receive recognition on the part of the physicians who have long decried the tendency of many state agencies to encourage an expansion of state-supported services. The hearing program shows what can be done through proper leadership of a well staffed state agency, and a constant desire on the part of the state employees to develop local leadership and the assumption of local responsibilities.

Recommendations

(1) That county medical societies and individual physicians give full support to the hearing program of the Bureau of Handicapped Children by way of giving medical assistance to local school authorities who are concerned with the development of a hearing program along the lines approved by the Committee on Hearing Defects.

(2) That medical auxiliaries be encouraged to assist in the screening programs, as many auxiliary members are

former nurses or have had sufficient contact with medical practice to understand the procedures which should be followed.

(3) That the otologic clinics be used by physicians who have special patient problems, and that whenever possible the physician visit the clinic with the patient and derive the benefits of consultation with the otologist serving the clinic.

The reference committee recommended adoption of the recommendations made by the Committee on Hearing Defects. On motion of Doctor Carlson, seconded by Dr. T. J. Aylward, Milwaukee, carried, this section of the report was accepted.

Committee on Hospital Relations

K. H. Doege, chairman; A. H. Barr; S. R. Beatty; K. F. Manz; Gorton Ritchie; P. C. Dietz

During the past two years the Committee on Hospital Relations has primarily concerned itself with an enunciation of a plan whereby hospitals and/or physicians, particularly those related to the specialties of anesthesia, pathology, and radiology, might have reviewed any "grievances" as to the nature and reimbursement of services through hospitals. This was developed at the suggestion of the American Medical Association to implement the so-called "Hess Report." Since the original report was acted upon by the A.M.A. House of Delegates, certain modifications have been made and have been reported to the general membership in the A.M.A. Delegates Report following the December 1951 A.M.A. meeting.

During this past year the Committee on Hospital Relations has had referred to it a proposal of the Kellogg Foundation that it supply personnel to conduct a survey in Wisconsin concerning the possibility of developing part-time radiologic and pathologic services among small hospitals. This was referred to the Committee on Hospital Relations at the request of the Interim Committee, and this is in the nature of a "progress report" on this particular project.

Early in 1952 all hospitals were contacted to determine to what extent they now have full-time or part-time radiologic and pathologic services. Because of many other activities the original survey was not followed up until last spring, and then the material was organized and an initial report made to a small coordinating committee, including the chairman of the Committee on Hospital Relations, the state health officer, and representatives from the Wisconsin Society of Pathologists, the Wisconsin Radiologic Society, the Wisconsin Hospital Association, and the Wisconsin Conference of Catholic Hospitals.

On the basis of this preliminary conference a completion of the survey was recommended, and further contacts made with members of the two specialty societies most directly involved, to see what further information can be compiled to show need or lack of need for the type of service suggested by the Kellogg Foundation.

Following the completion of this portion of the study, and a determination of conditions under which the study would be conducted in Wisconsin to the satisfaction of the Committee on Hospital Relations, a further report will be made to the Council or the House of Delegates concerning this matter. If the proposal has value in terms of professional education and the stimulation of local initiative in setting up facilities which will extend the services of radiology and pathology into areas not now adequately served, it is felt that the project is worthy of consideration. However, no proposal will be made or accepted which will run counter to the basic philosophy of the medical profession in relation to specialty services rendered through the hospital.

Recommendation

That medical staffs of hospitals, not now having the services of a radiologist or pathologist on a full-time or part-time basis, study the local situation to see if such services might be provided through cooperation with neighboring areas.

The reference committee recommended that this committee continue its study and offer suggestions and assistance to hospitals in obtaining at least part-time pathologic and radiologic services, and felt that the continuation of this survey is of great importance. Doctor Doege and his committee have spent considerable time and effort during the year in connection with the work of this committee.

On motion of Doctor Carlson, seconded by Dr. M. W. Stuessy, Brodhead, carried, this section of the report was accepted.

Committee on Maternal and Child Welfare

L. M. Simonson, chairman; R. F. Purtell; Amy Louise Hunter; J. W. Harris; A. H. Stahmer; Mildred Stone

The committee continues to provide advisory service to the Bureau of Maternal and Child Health of the State Board of Health and to take an active interest in all activities related to maternal and child care. Each year it has reviewed data which might point out new possibilities for saving the lives of more Wisconsin mothers and children. In its 1951 report approved by the House of Delegates this committee called attention to the need for further and more intensified study of maternal, fetal and neonatal deaths. Activities during the past year have focused upon this need.

The committee wishes to reemphasize the importance of accurate recording of all pertinent facts on birth and death certificates. In recent years the State Board of Health has been matching birth and infant death certificates and punching combined data. The same procedure is followed with maternal deaths. Discrepancies in the medical data occur with sufficient frequency so that the committee again feels it should stress the value of such records. The medical portion is the responsibility of the physician and is far too vital to delegate to the nurse or other hospital personnel. Data gathered from these records can help every physician and hospital in Wisconsin to provide the safest possible birth experience.

As progress has been made over the years, attention has come to rest more and more on fetal deaths (stillbirths) and neonatal deaths. The committee wishes to urge that care be taken in applying the criteria for determining what is officially recognized as a live birth. In looking with enthusiasm at the decreasing infant death rates, the fact that certain counties have disproportionately high fetal death rates, has until recently been overlooked. The following map focusing attention on the potential lives lost in relation to the birth experience should be of interest. We hope that every doctor and hospital will review their own experience.

Your committee feels that further reduction of fetal and neonatal deaths must depend primarily on the physicians providing prenatal care and the doctors and hospital personnel providing the delivery and immediate postpartum care. The best opportunity for saving mothers and babies rests largely in their hands. Many neonatal deaths are the result of obstetric problems.

In view of the still high percentage of premature deliveries, the committee once again wishes to emphasize the importance of an adequate diet for expectant mothers, adequate supervision with prompt attention to early complications, extreme care in the selection and administration of analgesics and anesthetics, prompt clearing of air passages and provision of oxygen and heated cribs for newborns, blood and plasma available for all emergencies, unusually close supervision of every mother and baby during the first 24 hours after delivery.

Maternal Death Study

An intensified study of maternal deaths will be launched in January 1953. Such a study is not new, but this will be Wisconsin's first state-wide study project of individual deaths. To succeed it will necessitate the best possible cooperation of all parties concerned. In drawing up the plan emphasis has been given to the fact that this is primarily an educational project directed toward offering physicians an opportunity to discuss their individual problems. The committee has profited by the experience of other states in setting up the essential steps:

WISCONSIN RESIDENT NEONATAL DEATHS

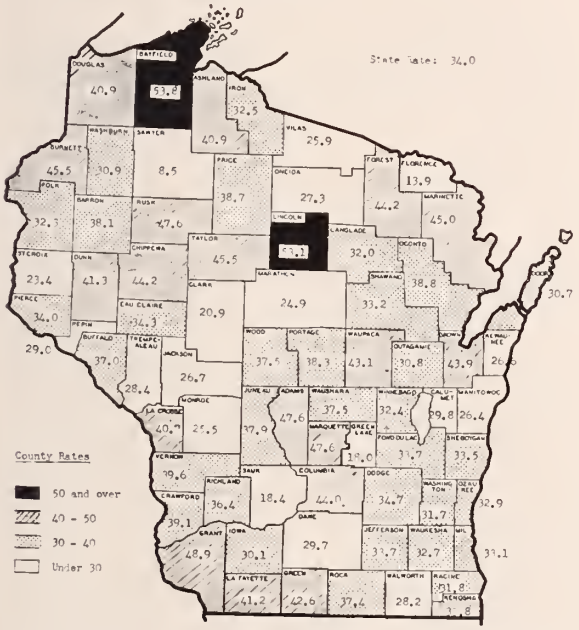
	1949	1950	1951
Congenital defect	203	228	261
Birth injury (cerebral and spinal)	85	73	70
Other birth injury	181	165	415*
Asphyxia and atelectasis	261	278	187
Pneumonia of newborn	43	66	28
Diarrhea of newborn	14	21	7
Other infections of newborn	3	2	2
Disorders regarding maternal toxemia	39	19	51
Hemolytic disease of newborn	60	64	87
Hemorrhagic disease of newborn	11	11	14
Nutritional maladjustment	4	4	4
Ill-defined diseases peculiar to infants	35	40	61
Immaturity with other subsidiary cond.	11	3	22
Immaturity, unqualified	592	547	395
Accidents	11	11	11
Unknown	4	2	1
All other	39	37	31
Total neonatal deaths	1,596	1,571	1,647
Total live births	82,736	82,034	87,819
Neonatal death rate (per 1,000 live births)	19.3	19.2	18.8

*In 1950 all infant deaths were matched with birth certificates before coding. In any instance where supplemental data on birth certificate showed a factor that helped in clarifying cause of death of infant, if both certificates signed by same physician, this information was used in making final appraisal of death cause.

LOSS OF POTENTIAL LIVES

(Combined Neonatal and Fetal Death Rate per 1,000 Live Births)

Wisconsin Resident Data—1951



1. Local registrars will be asked to transmit maternal death certificates, immediately upon receipt, to the State Board of Health. The Bureau of Maternal and Child Health will supply the Maternal and Child Welfare Committee with the name and address of the attending physician.

2. The Maternal and Child Welfare Committee will transmit a personal letter to the physician outlining the purpose of the study and soliciting his cooperation. It will be suggested that an "interviewer" from a panel of qualified physicians with extensive experience in obstetrics cooperating with the Committee on Maternal and Child Welfare be permitted to review the hospital records and to visit the doctor at a time designated by the physician to secure study data concerning the maternal death for evaluation. Physicians would be assured complete anonymity.

3. With the consent of the physician an "interviewer" would be sent to collect the data. This person would be selected from a rather extensive panel of Wisconsin physicians who, in the opinion of the Committee on Maternal and Child Welfare, would be qualified to conduct the interview so as to secure the needed information and assure the physician that the study was in no sense an "investigation." No individual will interview in the immediate area of the state in which he practices. They will be reimbursed by the State Board of Health at a rate not to exceed $50 per day toward travel and incidental expenses. If Board of Health funds are insufficient to finance the entire project, study funds will be requested from the Audit and Budget Committee of the State Medical Society.

4. Following the visit the "interviewer" will transmit, without identifying data, the report of his findings to each member of a special "study committee" composed of five or six well-qualified individuals, geographically located to permit meeting at least four times per year to review reports and prepare summaries. The members of the "study committee" will be appointed by the chairman of the Committee on Maternal and Child Welfare and will be directly responsible to that committee. Interested physicians may attend sessions of the reviewing committee if they desire.

5. Each physician and hospital involved in any case will receive a report of the final summary. From time to time summaries of selected cases, without identifying data, will be prepared for publication in the Wisconsin Medical Journal when the special problems illustrated would be helpful to all physicians.

To attain the objectives of this maternal mortality study the Committee on Maternal and Child Welfare hopes to develop an awareness on the part of all attending physicians that even though the maternal mortality rate in Wisconsin is the lowest in its history and is one of the lowest in the entire nation, there still are steps which could and should be taken to reduce this loss of life to an even greater degree.

Neonatal Study Needed

It is the hope of the Committee on Maternal and Child Welfare that a similar study can be launched in reference to neonatal deaths. While the number would be too great to suggest a state-wide research project, it is hoped that during the ensuing year some representative hospitals will be interested in making pilot studies. On the basis of such localized research some basic consideration could be given to measures which physicians and hospitals might take in saving many of the lives now lost.

Recommendations

(1) That all hospital staffs intensify their efforts to study maternal, fetal and neonatal deaths.

(2) That attention be concentrated on entering on death certificates any pertinent information relating to delivery that will aid in accurately classifying maternal and infant deaths, especially since certain infant death causes are primarily the result of such maternal complications as "other birth injuries" and "toxic conditions," whether toxemia of pregnancy, diabetes or the result of virus infection.

(3) That every physician and hospital keep clearly in mind that any baby after delivery from the birth canal, even prior to delivery of the placenta, is liveborn if it has such evidence of life as heartbeat, respiration or voluntary muscle contraction.

(4) That individual physicians be encouraged to cooperate with the Committee on Maternal and Child Welfare to develop a better understanding of the many factors contributing to maternal deaths and to determine to what extent improved medical procedures and hospital practices can result in further reduction of maternal and infant deaths.

(5) That selected hospitals be encouraged to conduct pilot studies on neonatal and fetal deaths as a basis for considering preventive measures, and that *all* physicians and hospitals cooperate to the fullest extent with the maternal death study which this committee of the Sate Medical Society will launch this coming year.

The reference committee called particular attention to the fact that the study of maternal deaths, which will be started in January, 1953, will be Wisconsin's first statewide study

project of individual deaths, and to succeed it will necessitate the best possible cooperation of all parties concerned.

To give the House of Delegates further insight into the extensive amount of work and study that Doctor Simonson and his committee have done, the reference committee incorporated a summary of the remarks made by Dr. T. A. Leonard, who appeared before the committee with Doctor Simonson, to urge adoption of the recommendations.

Doctor Leonard stated that the Committee on the Maternal Mortality Study has circularized every state in the Union to determine its methods of conducting such a survey, and has received replies from each of them. These reports have been reviewed with great detail, and from this study the committee has devised its own method with the intent of making the maternal mortality study one that will be of great educational value to all concerned.

A committee of 20 physicians has been formed to conduct interviews and to determine all of the factors concerned in each maternal death from the standpoint of the hospital, the family, and the physician; and this information will be presented in detail to a committee which has been created to make a study of these deaths, without any identification of those concerned.

Eventually, as this material accrues, it is planned that the study committee will appear before appropriate committees or groups of the State Medical Society, to conduct a typical study showing how the committee works, and the factors that enter into the prevention of maternal deaths.

The reference committee was impressed greatly by the immensity of the time devoted to this study, and felt that the Society is greatly indebted to this committee for its efforts, and recommended adoption of the recommendations of the Committee on Maternal and Child Welfare.

Doctor Carlson moved that this section of the report be accepted. The motion was seconded by Dr. T. A. Leonard, Madison, who when granted the privilege of the floor, offered the following additional comments to the House of Delegates:

"As you all will recall, in 1951, at the meeting of the House of Delegates, permission was requested to be given to a committee to set up such a study program. These programs have been conducted in many other states in the Union, and it has been found from all of the studies that at least 50 per cent of the maternal deaths that occur are preventable.

"It was the intent and purpose of our own committee to study all of the methods and details that entered into these maternal mortality studies, and we have done so. We think we have come up with something better than anything that now exists.

"We owe particular gratitude to the Minnesota group, because we feel that we have received more help from it than from any other state group in the country.

"This program is going to be one that we feel will be of great interest and help to all of us. It is not planned that this study be anything in the way of a gestapo investigation, or anything of that kind. It is going to be an interview, with the intent of determining all of the factors that enter into any given maternal death.

"When the reports of the interview are made up, they will come back to the study committee, which will receive that information in a purely anonymous fashion. It will have no earmarks that will determine the locale of the death, nor the physician under whose care the patient was at the time of death, nor the name of the patient. Therefore, the matter can be reviewed impartially by the committee, and determination made as to whether or not such a death was preventable or not.

"For the deaths that are preventable it is felt that we then will have material that will furnish us with educational information. We are grasping at straws now to further reduce maternal mortality. The major factors of infection, hemorrhage, and toxemia are fast disappearing from the picture. We are now dealing with medical complications of pregnancy as a major cause of maternal mortality.

"It is our hope that as this study progresses and as the information comes to us, we then can be of some assistance in preventing 50 per cent of the current maternal deaths."

The motion was put to a vote and carried unanimously.

Committee on Mental Hygiene, Institutional Care, Public Welfare and State Departments

A. M. Christofferson, chairman; P. R. Minahan; Joseph Lettenberger; E. D. Schwade

During the past year the major attention of this committee has been directed to a study and report on the subject of epilepsy and marriage. At the request of Dr. E. D. Schwade, Milwaukee, a special subcommittee on this subject was appointed to study the problem with special reference to restrictive portions of the Wisconsin Statutes, in which the epileptic is classified with the mentally defective, the imbecile, and the idiot as being incapable of contracting marriage.

Several meetings of this special subcommittee were held during the year, and considerable study was directed to recent scientific literature on the subject of epilepsy and inheritance, as well as a study of other state laws. On the basis of these special inquiries and after consultation with legal counsel regarding the most feasible approach to the problem, it was recommended that the words "or epileptic person" be stricken from Section 245.03 (1) of the 1951 Wisconsin Statutes. This recommendation was made to the Council on May 18 with the suggestion that the Committee on Public Policy be directed to introduce such legislation and support its passage. The Council approved of the recommendations.

Special problems of commitment procedures and the psychotic child were brought to the attention of the committee, with a request that special subcommittees be appointed to study these special problems during the ensuing year and make a report which will be transmitted to the House of Delegates in 1953.

The Committee on Mental Hygiene is pleased to report great strides in the care of the mentally ill during the past year. The continued leadership of Dr. Leslie Osborn as medical director for the Division of Mental Hygiene of the Department of Public Welfare has charted a long range course for all of the mental institutions and for a more intensified study of mental illnesses through the University of Wisconsin Medical School and expanded facilities at Mendota State Hospital. It is hoped that legislative support for many of these programs can be secured, so that more research can be directed in the many fields which have been neglected, due to more immediate problems of housing.

The committee notes with sincere sorrow the death of one of its members, Dr. B. J. Hughes, former superintendent of Winnebago State Hospital, who served as an active member of the Committee on Mental Hygiene for many years, and provided the committee with enthusiastic and forceful leadership on many projects which were carried out.

There are many pressing problems which confront those most closely associated with the mental hospitals in Wisconsin. While our state hospital facilities have been improved during the past several years both as to physical facilities and to trained personnel, there is still a regrettable overcrowding and deficiency of the best type of program at the Northern and Southern Colonies. This is in no sense an indictment of the administration of either institution, as the population is far too heavy to carry out the program which each administrative head would like to achieve. Some of the most pressing problems at Mendota and Winnebago have been relieved, but such is not the case at the institutions set aside for the care of the mentally deficient children in Wisconsin.

Our county institutions still range from good to substandard, medically speaking. While many have sincere medical direction, others are little more concerned with the care of the patients than in the net financial returns of the farms run in connection with the institutions. While some attention has been directed to the meeting of the minimum standards set by this committee and approved by action of

the House of Delegates several years ago, there are many county institutions for the care of the mentally ill which fall far short of the very basic standards set forth in that report. The answer is more full-time medical direction and more supervision provided by Doctor Osborn's now overworked staff.

In a recent report to the Committee on Mental Hygiene Doctor Osborn called attention to the high incidence of tuberculosis in many county institutions for the mentally ill, and the relatively few instances where effective isolation methods are set up to avoid contact spread of infection. The Committee on Mental Hygiene has suggested that this particular problem be taken up with the Committee on Tuberculosis and Chest Diseases.

During the past year the Department of Public Welfare has sought to reorganize completely the Bureau of Alcohol Studies, and with the recent appointment of a permanent director it is anticipated that special problems in this field will be reviewed by many interested groups, including the Committee on Mental Hygiene.

During the past year a special Interim Committee of the Legislative Council has been studying various problems relating to the aged. One meeting was devoted to medical aspects of this problem, and Drs. Nels Hill, Murray Angevine, and C. N. Neupert presented reports which provided the committee with valuable information on the aging process, current medical research in geriatrics, and related subjects.

Recommendations

(1) That county medical societies periodically review the medical supervision of medical institutions in their county and continue to advocate more adequate financial support so that proper standards of supervision and medical care can be assured.

(2) That support of all physicians be given to legislation relating to the epileptic and marriage, which will free the epileptic from the restrictive features of Section 245.03 (1) of the 1951 Wisconsin Statutes.

(3) That any physicians who are confronted with medical problems related to commitment procedures assist the Committee on Mental Hygiene in the study it is conducting, by transmitting information and opinions to the committee chairman.

(4) That the State Medical Society lend support to the efforts of the Division of Mental Hygiene of the Department of Public Welfare in expanding the teaching facilities at the University of Wisconsin Medical School through special research projects and the larger concentration of teaching material at the Medical School and Mendota State Hospital.

The reference committee recommended adoption of these recommendations. It stated that Dr. A. M. Christofferson, chairman of the committee, appeared in person before the reference committee, which was impressed with his sincerity and with the conscientious efforts of Doctor Christofferson and his committee.

On motion of Doctor Carlson, seconded by Dr. J. W. Fons, Milwaukee, carried, this section of the report was accepted.

Committee on Public Policy

J. M. Sullivan, chairman; M. G. Rice; J. K. Curtis; S. E. Gavin; J. R. Schroder; President, ex officio; President-elect, ex officio; Secretary, ex officio

Under the Constitution and By-Laws of the State Medical Society this committee is charged with the responsibility of representing the judgment of the profession as to various proposals presented before the State Legislature, both by the State Medical Society and by other parties who express interest in the health field.

By direction of the Council, as well as on its own initiative, the Committee on Public Policy is engaged in a detailed study of the Medical Practice Act. In some respects the act contains provisions which are obsolete and others which are not entirely clear and in some instances not attuned to the development of scientific medicine.

For example, the present Wisconsin Statutes provide that the State Board of Medical Examiners shall consist of eight medical physicians and surgeons and one osteopathic physician and surgeon. In the case of the medical representatives three shall be allopathic, two homeopathic and two eclectics, with no member of the Board permitted to have any affiliation with any college or university having a medical department.

It seems obsolete to require that qualifications for appointment be directed to the recognition of homeopathy and eclecticism.

Other problems confronting the committee in its study involve the Basic Science Law which Wisconsin was the first state to enact. There are many states that have followed Wisconsin's leadership, but in so doing have not specified the identical subjects. At the present time, while Wisconsin designates anatomy, physiology, pathology and diagnosis as the basic sciences, other states have added public health, bacteriology, chemistry and hygiene.

This creates two problems of concern to the medical profession in Wisconsin, the first being whether the Wisconsin law is sufficiently comprehensive as a screening process in public health interest, and the second, the problem of reciprocity between states. For example, one of our neighboring states does not include diagnosis as a basic science, but does include three additional subjects not in the Wisconsin law. Thus, physicians in Wisconsin and physicians in that state practicing along the state line find the necessity of examination in the subjects not included in the state in which they have their original license.

Another matter under consideration of the committee is the current requirement that a physician's license be registered in the county in which he resides, a provision that has been in existence for some years, and which was not modified when annual registration with the State Board of Medical Examiners was first required in 1943.

The above merely represents some of the problems which the committee is currently studying and does not include all suggestions under consideration. In addition, the committee anticipates the necessity of considering suggestions emanating from chiropodists, masseurs and others in limited fields who have proposals of their own and which will require careful evaluation.

The committee contemplates a rather intensive series of meetings to conclude probably late in November, and will at that time discuss its final recommendations with the Council.

Because these may be of considerable consequence and require the understanding of physicians throughout the state, it may also be suggested that its report not only be distributed to every physician member of the State Medical Society, but that through committee and staff personnel, efforts be made to discuss committee recommendations in various county and district medical meetings.

The reference committee recommended acceptance of the report of the Committee on Public Policy, and on motion of Doctor Carlson, seconded by Dr. Charles W. Giesen, Superior, this section of the report was accepted.

Council on Scientific Work

W. S. Bump, chairman; T. O. Nuzum; J. W. Gale; S. A. Morton; P. A. Midelfart; R. S. Baldwin; J. S. Hirschboeck; W. S. Middleton

During the past year the Council on Scientific Work has directed its major attention to revisions in the Annual Meeting program and the development of a far more comprehensive regional postgraduate teaching program than had been conducted formerly. In cooperation with the two medical schools, the State Board of Health, the Wisconsin

Academy on General Practice, W.A.T.A., the Wisconsin Division of the American Cancer Society and the Wisconsin Heart Association, the Council has presented 15 regional conferences patterned after the "spring clinic" type of meeting conducted so successfully since 1942. In addition evening teaching programs at hospitals were provided in six teaching sites twice during the early spring months.

The wide acceptance of these programs is attested in the enrollment of more than 600 physicians, which represents approximately 20 per cent of the entire membership.

In addition to the circuit programs conducted this past year, a single, and very successful, clinic was held in northwestern Wisconsin on June 18 with faculty members from the two medical schools as speakers. The enthusiastic response of more than 100 doctors and their wives in attendance has again demonstrated the desirability of providing postgraduate teaching on a regular basis for our members in the northern part of the state.

On the basis of this past year's experience the Council has directed Dr. Joseph Gale to prepare similar types of programs which will be announced to the general membership within the next month. It is hoped that the conferences will be as well received as those offered in 1952.

Those attending the scientific programs of this Annual Meeting will see that the Council has inaugurated several changes which it is hoped will make the programs of more direct value to the many general practitioners in attendance. Section meetings as such have been discontinued, with the exception of the Section on Ophthalmology and Otolaryngology. In their stead is offered a series of symposia or related papers on topics identified with the subjects of internal medicine, obstetrics, pediatrics, surgery, and radiology. It was felt that this approach to specialty topics, related to the general program, would be more realistic than the presentation of separate section meetings.

Also, it will be noted that more attention is being directed to small group teaching programs each day, in addition to the small luncheon discussions which have proved so popular in the past. This continued emphasis on direct teaching has been prompted by responses of physicians who have attended previous Annual Meetings and have commented favorably upon the decreased emphasis placed on didactic lectures and corresponding increased emphasis upon direct teaching and the development of scientific exhibits which provide a similar teaching approach.

The Council on Scientific Work has had the splendid cooperation of Dr. R. S. Baldwin in editing the scientific section of the Wisconsin Medical Journal, and this brief report would be incomplete without acknowledgment of the fine editorial direction Doctor Baldwin has given the official publication this past year. With a decrease of formal papers presented at the Annual Meeting and made available for publication in the Journal. Doctor Baldwin has developed other sources of good scientific material from the two medical schools, the Wisconsin Society of Pathologists and the general membership itself, which provide articles of outstanding quality. The Council is most appreciative of the time and effort Doctor Baldwin has given to make our official publication outstanding among state journals in respect to the scientific material presented.

Recommendations

The Council on Scientific Work has no specific recommendations to make other than to urge members to participate in the various postgraduate teaching programs offered, and to assist us by way of presenting constructive criticisms so that future programs can be developed which will have even greater value to our members.

The reference committee recommended adoption of this Council's suggestion that members participate in the various postgraduate teaching programs offered and assist by way of presenting constructive criticisms so that future programs can be developed of even greater value to the members. The reference committee stated that in recognition of the tremendous amount of time and detail necessitated in the work of such a committee, it wished to express, on behalf of the Society, its personal appreciation to Doctor Bump and his committee for the work they have done.

On motion of Doctor Carlson, seconded by Dr. O. O. Meyer, Madison, carried, this section of the report was accepted.

Committee on Tuberculosis and Chest Diseases

J. D. Steele, chairman; A. A. Pleyte; W. T. Clark; H. A. Anderson; L. W. Moody

The major concern of the Committee on Tuberculosis and Chest Diseases this past year was to advise with representatives of the Wisconsin Anti-Tuberculosis Association in reference to a proposed change in policy of the W.A.T.A. whereby the consultation service of W.A.T.A. would be withdrawn and other forms of education and service substituted.

This consultation service to county tuberculosis sanatoria was originally set up as a demonstration project to show what type of case study would be desirable, and what methods should be employed to secure the best possible evaluation of individual patient cases. Over the years this has become an accepted service on the part of many institutions, and the original objection of serving as a demonstration program was lost.

W.A.T.A. now feels that there are other types of educational services which should be developed and can only be realized as there is a shift away from the consultation service provided. Recognizing that such a departure might be misunderstood, with resulting adverse public relations, the W.A.T.A. has met with many interested groups to discuss the matter and reach an understanding of how the service can be withdrawn without resulting decline of patient care.

The Committee on Tuberculosis and Chest Diseases was consulted regarding this problem early in the year, and it has assisted the W.A.T.A. in formulating a policy which it is hoped will be understood and accepted by the medical profession as well as the lay public. The committee feels that every support should be given W.A.T.A. in the transitional stage, and that W.A.T.A. be given encouragement to develop new and varied types of professional and educational services.

A second problem which was brought to the attention of the Committee on Tuberculosis and Chest Diseases was criticism of the state auditor for policies employed by the State Board of Health in reimbursing staff personnel of the State Board of Health for interpretive reading of x-rays from mobile units after working hours. The problem was thoroughly reviewed with the state health officer, and the Committee on Tuberculosis and Chest Diseases expressed an unofficial opinion that the service, as set up by action of the State Board of Health, was sound in terms of good medical practice and in terms of service to patients x-rayed, by utilizing qualified physicians who are conversant with the objectives of the screening program. It was recommended that if the state authorities would insist on "outside reading," careful consideration should be given to qualified physicians who are cognizant of the problems of tuberculosis screening and will continue the procedures of the program which has been so successful to date.

Attention was drawn to certain suggested changes in the Wisconsin Statutes relating to the outpatient care of tuberculous patients. The Wisconsin Trudeau Society feels that Section 50.08 of the 1951 Wisconsin Statutes is too broad as a "free treatment" program, inasmuch as the present wording of "other pulmonary diseases" in Section (1) of 50.08 would, in the opinion of many physicians, take in such things as asthma, polio, and many other diseases not related to tuberculosis. The Committee on Tuberculosis and Chest Diseases has suggested that possible revision of this section of the statutes be considered by the Committee on Public Policy, and inasmuch as it is known that the Wisconsin Sanatorium Trustees Association feels the present wording is more desirable, that "hearings" be held before the Committee on Public Policy to present the varying viewpoints. After that the Committee on Public Policy can determine whether or not it wishes to recommend to the Council

of the State Medical Society that legislation on this subject be introduced.

Several problems relating to thoracic surgery have been brought to the attention of the committee at too late a date to incorporate recommendations in this report. It is anticipated that an early meeting will be held with representatives of the Trustees Association, the State of Wisconsin General Hospital, and the State Board of Health to discuss some of these problems, and the next report of the committee will have some comments and recommendations to make on this subject.

Recommendations

That all physicians in anyway connected with tuberculosis sanatoria lend their support to the revised program of W.A.T.A. and use their influence to see that those agencies supporting the various services provide sufficient funds so that adequate consultation can be assured, with resulting benefit to the patients served.

The reference committee recommended adoption of the committee's recommendations and commended it for a splendid job. On motion of Doctor Carlson, seconded by Dr. J. W. Fons, Milwaukee, carried, this section of the report was accepted.

Committee on Visual Defects

J. B. Hitz, chairman; E. J. Zeiss; H. J. Belson; T. J. Doyle; T. B. McNamara

At the present time there is no vision program in Wisconsin which is comparable to the hearing program of the Bureau of Handicapped Children. Part of this is due to the fact that there is no screening device which has been entirely accepted and is completely accurate. In most instances the Snellen test is being used, with generally satisfactory results. In some areas the American Optical sight-screening instrument is being used, but this requires rather skilled personnel for the screening program, and so it has not been accepted as widely as the Snellen test.

The Wisconsin Optometric Association has shown a disquieting aggressiveness in promoting screening programs in which members of their organization would provide the services of optometrists in the actual screening, and then make available to all those who might need a more intensive eye study a list of qualified optometrists in the community. The Committee on Visual Defects feels that such a program is highly unethical, as it places the person who is to render the service in a position where he is, in a sense, advertising his own services through his contacts with children, teachers, and parents as participants in the screening program.

The Committee on Visual Defects urges all county medical societies to cooperate with local school authorities in giving medical guidance to the development of a screening program which will maintain high standards of medical ethics, and follow procedures which will not place any one physician or a group of physicians in a position of exploiting their own services.

It is anticipated that during the ensuing year some constructive suggestions can be provided county medical societies to assist them in the development of a screening program which will improve the case finding program through the public and parochial schools.

The Bureau of Handicapped Children recognizes that there is much to be done for the visually handicapped in Wisconsin, and steps have been taken to improve the services offered through that state agency. A report to the Committee on Visual Defects this past year indicates that intensified study of each individual child at the residential school at Janesville has been undertaken, and, in addition, all of the children at the school have had regular audiometric hearing tests and otologic examinations in case there is any evidence of hearing impairment as well as sight loss.

The Bureau also reports nine special "sight-saving" day school programs, with 135 children enrolled.

The Bureau is conducting a pilot screening study in Dane County, and further reports on this will be made at a later date. While the Bureau of Handicapped Children does not contemplate the development of a visual program on a statewide basis, the medical director, Dr. Maxine Bennett, is available for consultation with any county medical society which wishes to develop a program on a county basis.

The Wisconsin Council for the Blind has indicated that many doctors were not conversant with services available for those who have lost their sight, or whose sight loss is progressive and irremedial. The Committee on Visual Defects prepared a special insert for the Wisconsin Medical Journal and has directed special communications to those in the eye, ear, nose, and throat field, with report forms directed to the Division of Public Assistance Services to the Blind, so that state agencies prepared to assist the patient with rehabilitation and occupational therapy can be brought into the picture before neglect and isolation have developed emotional problems which would retard complete and satisfactory adjustment. It is hoped that all physicians, as they are confronted with cases of blindness or impending blindness, will secure permission from the patient to report the case to the Division of Public Assistance Services to the Blind on the report form furnished, so that the particular state agency prepared to assist can be brought in contact with the patient as soon as possible.

Recommendations

(1) That county medical societies make known to all school administrators that they are prepared to assist with a visual program among children of school age, along the lines of ethical medical practice and in keeping with general principles laid down by the Committee on Visual Defects and the Bureau of Handicapped Children of the Department of Public Instruction.

(2) That any visual program conducted in Wisconsin schools be under proper medical supervision, with actual screening done by teachers, public health nurses, or lay personnel properly trained for such preliminary evaluation of gross visual deficiencies; and that physicians or others who will be asked to conduct a more critical evaluation of visual deficiencies, not be used in the preliminary screening program.

(3) That all physicians use the recommended report form, provided through the State Medical Society, to acquaint the Division of Public Assistance Services to the Blind with a case of blindness or impending blindness so that rehabilitation can be started at the earliest possible moment.

The reference committee recommended that number (2) of the recommendations above be amended, and following discussion, on motion of Dr. A. H. Pember, Janesville, seconded by Dr. J. F. Moon, Baraboo, carried, number (2) of the recommendations was amended to read:

"That any visual program conducted in Wisconsin schools be under proper medical supervision, with actual screening done by teachers, public health nurses, or lay personnel properly trained for such preliminary evaluation of gross visual deficiencies; and that those who give subsequent eye care, medical and non-medical, who will be asked to conduct a more critical evaluation of visual deficiencies, not be used in the preliminary screening program."

The reference committee further recommended adoption of the recommendations as amended, and expressed its appreciation for the suggestions offered by Doctor Hitz and Doctor Zeiss, who appeared before the reference committee.

On motion of Doctor Carlson, seconded by Dr. A. H. Pember, Janesville, carried, this section of the report was accepted.

On motion of Doctor Carlson, seconded by Dr. F. E. Drew, Milwaukee, carried, the report of the reference committee as a whole was approved.

REPORT OF REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BY-LAWS

This reference committee was composed of Drs. H. E. Kasten, Beloit, chairman; E. D. Sorenson, Elkhorn; T. W. Tormey, Jr., Madison; O. G. Moland, Augusta; and J. M. Sullivan, Milwaukee.

Reports considered by the committee were printed in the Delegates Handbook, as well as introduced in the House of Delegates through supplementary reports.

Report of the Council

The printed and supplementary reports of the Council, as published on pages 1245–1254 of this Journal, were recommended for approval by the reference committee, with special emphasis on the recommendation of the Subcommittee on Epilepsy and Marriage of the Committee on Mental Hygiene. This subcommittee urged that the word "epileptic" be deleted from the Wisconsin statutes, which declare at the present time, "No insane, imbecile, feebleminded or epileptic person or idiot shall be capable of contracting marriage."

The reference committee concurred with the opinion that the epileptic person is a normal person except for his epileptic seizures, and that the law should be amended in such manner.

On motion of Doctor Kasten, seconded by Dr. T. J. Aylward, Milwaukee, carried, this section of the report was accepted.

With regard to the supplementary report of the Council concerning the recommendation that "section delegates be without right to vote, but having all other privileges accorded delegates," it was the recommendation of this reference committee that the matter be made the subject of further study by a committee composed of the Speaker of the House, the Vice-Speaker of the House, and the President of the Society, who would report to a subsequent meeting of the House.

On motion of Doctor Kasten, seconded by Dr. A. H. Pember, Janesville, carried, this section of the report was accepted.

Report of the Commission on Prepaid Health Care Plans

With action completed by the House of Delegates in the fall of 1951 instructing the development of Wisconsin Physicians Service and policies of the Wisconsin Plan to include full-payment benefits to two different income levels, and with the use of two different schedules, the administrative organization of the State Medical Society was developed rapidly to carry out this mandate.

In November 1951, the Council of the State Medical Society, under the authority given to it by the House of Delegates, organized the Commission on Prepaid Plans and assigned to the jurisdiction of that Commission not only the two prepaid plans, but an experimental plan in Price–Taylor County, and the relationship of the Society with the Wisconsin Interscholastic Athletic Association and its student accident benefit program.

The Council delegated to the Commission authority in all fields except as to specific matters in which the Council reserved the right to make the final determination based upon the recommendations of the Commission.

The Commission is directed to meet quarterly, and its organization includes an Executive Committee and Committees on Blue Cross, Claims, Enrollment and Underwriting, Research and Development, and Physician and Public Relations.

Shortly following Council action, the first meeting of the Commission was held in mid-December 1951. During preceding weeks, by direction of the Commission members, the administrative staff, including actuaries, certified public accountants, and legal counsel, conducted an intensive detailed review of the procedures necessary to place the new program in as early operation as possible. It would burden the reader with many added pages were a detailed list of these projects included in this report. The specifications for the program had to be written with careful attention to action by the House and the intent of the report submitted to the House. All contracts—group, non-group, and conversion—of Wisconsin Physicians Service had to be completely revised and plans completed for development of sales and promotional material, panels of participating physicians, and revised administrative procedures to handle the complications encountered by Wisconsin Physicians Service when contracts would be outstanding under the old plan and under the "A" and "B" schedules.

More than 25 meetings of the Commission and its several committees have been required, and prior to the first formal Commission meeting a two-day session was held with the administrative staff of Blue Cross, representatives of Wisconsin Plan companies, and the staff of the Medical Society.

Out of all these meetings, plus the inevitable conferences, studies, necessary discussions with various state officials, and at the same time keeping abreast of developments by other plans, the Commission on Prepaid Plans of the State Medical Society can report its satisfaction in having achieved a degree of progress against obstacles that seemed so formidable that at one point there was serious doubt whether the new program could be actually in effect and available to the public prior to the meeting of the House of Delegates scheduled in October 1952. The Commission does not desire to overemphasize the problems it has encountered, but to give any impression that these problems were neither in great number nor insignificant, would be to convey a grave misimpression.

The fact remains, however, that the programs became available April 1, 1952, and on July 1, 1952, except for isolated instances, no further installations of the obsolete program were made. It is as yet too early for the Commission to submit a report evaluating progress, results, and experience in the development of the new programs. This report can, at the best, summarize certain high lights and certain phases of activities in their development.

Wisconsin Plan

Since the establishment of this plan by the House of Delegates in the fall of 1945, there have been expenses incurred by the Society in developing that program, including legal, actuarial, and secretarial advice, clerical and mailing expense, and the handling of claims where disputes existed on the part of the physician or patient toward the proposed settlement, or where the insurance company itself had questions to ask. Such expenses were borne by the State Medical Society in an estimated annual amount of about $5,000.

Prior reports and details concerning this situation have been complete and made both to the House of Delegates and the Council.

However, there seemed to be misimpression within the profession itself as to the necessity of such expense; and such misimpression resulted in the conclusion that the State Medical Society was in some fashion underwriting the actual administration of insurance policies or their benefits. This, of course, was not true, and the expense incurred by the Society related directly to physician interest and the satisfactory handling of physicians' problems in connection with the Wisconsin Plan.

Through negotiations instituted by the Commission on Prepaid Plans, an arrangement was worked out by participating companies whereby reimbursement of these expenses on an annual and cost-analysis basis has been developed. At the time of writing this report, 11 insurance carriers have indicated their desire to continue the Wisconsin Plan under new specifications and have remitted $500 each to the Society as an advance payment toward claims and other administration expense. Seven carriers have indicated that they will not write the new Wisconsin Plan for the present. Others have yet to be heard from.

At the end of June 1953, all costs relating to the Wisconsin Plan will be fully detailed and reported; and if the amount remitted proves insufficient for that period of time, the participating companies have agreed to provide as much more as may be necessary to balance the account. If the amount paid by participating companies proves more than sufficient, a credit will be extended toward the ensuing year.

One company, which has determined that it will not continue writing the Wisconsin Plan under the new specifications, has nevertheless paid the Society $250 as its contribution for the months remaining in which some of its contracts under the old specifications will be in force.

Therefore, the Commission can report that expenses of the Wisconsin Plan are being borne by the companies and none of those expenses by the Society.

Administrative Staff

Under direction of the Commission, the secretary has further expanded the administrative staff during the past year and provided certain installations and assistance that assure greater efficiency and better understanding of the Society's efforts in the prepaid movement.

The major activities involved in connection with Wisconsin Physicians Service have been departmentalized in such manner that department heads hold parallel positions and specific responsibility in various fields. Members should appreciate that Wisconsin Physicians Service is one of the relatively few Blue Shield plans that has a clearly developed field of actuarial studies conducted by independent consulting actuaries. Certified public accountants and legal counsel hold similar positions. That is, each of these three consultants receives his appointment and is responsible to the State Medical Society rather than to the staff, as such, a recommendation made by the secretary and fully endorsed by the Commission and the Council. This assures the independence of these consultants to report directly to the physicians upon such matters as they feel warrant such direct reporting, or which cannot be determined within the administrative staff.

Claims, Business Administration, Accounting, Physician and Public Relations, and Field Service have been departmentalized to greater effectuate responsible administration.

A statistical division within the Accounting Department has been created and is under the immediate direction of an individual especially trained in this field. Certain basic IBM equipment has been obtained so that machine punch cards and other modern devices for obtaining an accurate and rapid statistical reporting are being used. Further installations along this line will be completed as this highly specialized type of machinery can be secured.

Legal Studies

The legal problems, which arise in connection with the planning and operation of the programs, are involved as well as numerous. Each participating physician states his willingness to accept the schedule of benefits in full payment of his services when they fall within the terms of the contract with subscribers, and when the subscribers fall within the prescribed income limits entitled to the full-payment feature of the programs.

The State Medical Society, operating its division known as "Wisconsin Physicians Service," or "Blue Shield of Wisconsin," contracts with individuals. The so-called "group contracts" are actually individual contracts of a particular type written with subscribers who belong in groups of various sizes. For those who leave groups, conversion contracts are available. For those who do not belong to groups, a special individual nongroup contract is available. For those who go into military service, still another special contract is available to the spouse and dependents under 19 years of age.

The House of Delegates and the Council establish the broad policy of the full-payment programs, including such fundamental points as income levels recognized for full payment, fee schedules, the types of coverage and the kinds of contracts to be written.

All of these policy decisions are based on professional and social considerations and on sound requirements of public health, and actuarial, statistical, accounting, and other considerations. They must ultimately be phrased in terms of working arrangements or rules. This is one of the major provinces of the legal staff under direction of the Commission. Drafting must follow not only the broad outlines of the House of Delegates, the Council, and the Commission, but also administrative, accounting, statistical, and actuarial considerations, problems, and recommendations reported by specialists in those respective fields. Such drafting must also be consistent with those portions of the Wisconsin insurance code and general contract or agency law which apply to the operations of Wisconsin Physicians Service.

The legal staff of WPS is under the necessity of integrating such diverse materials as medical policy, actuarial recommendations, statute law and court decisions, and trying to piece them together into usable, intelligible wording. Besides contract phrasing, application cards had to be revised for each type of contract, as did the literature relating to it. Such literature has to be consistent with the actual provisions of each contract so as to avoid legal and public relations conflicts which would inevitably result were the advertising material to vary from the contracts themselves.

The drafting of any one of these contracts involves the necessity of making decisions as to what words shall mean. When the word "surgery" is used in the contract, what does it mean? What does the phrase "medical service" mean? What is meant by "hospital day"? What does "full payment" mean? Who is entitled to and what is "maternity care"? What conditions or procedures call for a waiting period, and how long is it to be? Does WPS agree in any way to furnish a physician to a person holding one of its contracts? What legal liability could the State Medical Society incur from the operation of the WPS plan? Does the term "dependent" include children of all ages, and parents of the subscriber or of the subscriber's spouse?

The above represent a small portion of the literally hundreds of questions which have to be considered and answered in developing a contract. That is why a contract cannot be expressed in a hundred words, nor even accurately summarized in a hundred words. Some of the phrasing of a contract is inserted to assure freedom of professional judgment to the physician and freedom of choice to the patient. Other provisions are put in to clarify intent and to minimize misunderstanding. Still others are put in as safeguards to prevent intended or unintended demands on the plan in excess of its financial capacity.

As earlier indicated in this section of the report, it is necessary to satisfy not only the requirements of the medical profession as laid down in its policy or other decisions, but also questions of actuarial, accounting, statistical, underwriting, and administrative judgment, and finally the known or the prudently probable requirements of the law. Care must also be observed to prevent this prepayment program from fixing patterns of medical service. That field must remain exclusively with the individual practitioner and be a matter of his best judgment in a particular situation. A prepayment program would be guilty of an incalculable disservice were it to impose, designedly or otherwise, patterns for the rendition of professional services. It is an economic device and nothing more, although the social planners would be very glad to make it something more than that.

After contracts have been written and placed in force, legal questions inevitably arise in connection with certain claims. There are sometimes problems of eligibility to benefits. Not infrequently there are questions calling for interpretation of the contract. Questions sometimes arise which were not foreseen when the contract was drafted. Thus, advice has to be given on a continuing basis by the legal staff in connection with pending claims.

The attorney for WPS meets with the committees of the Commission on Prepaid Plans and advises with respect to the various problems which come before each of them. The chief reasons for his doing so are that he is familiar with the work of the various specialists who advise the plan, that he has familiarity with the general law which applies to the plan, and that he can help give a certain uniformity of approach and phrasing to the recommendations and decisions of the several committees.

While a number of claimants and attorneys have from time to time threatened to bring suit to enforce a certain settlement or a certain construction of the several contracts, it is a pleasure to be able to report that to date WPS has been sued only twice, and that in neither case was there anything more involved than the alleged liability of the plan to pay certain benefits. From April 1, 1947, when WPS first wrote contracts with subscribers, through June 30, 1952, 133,077 claims had been paid. It should be said in fairness

to the general public and the bar of this state that at no time has there been evident any disposition to criticize the program or the contracts on a carping or destructive basis, much less to challenge their legality. It is believed that this is a tribute primarily to the medical profession of Wisconsin for the fidelity and consistency with which it has supported the plan and rendered services under it.

Since WPS began its operations, certain of its promotional, selling and billing functions have been performed by Associated Hospital Service, Inc. (Blue Cross) as an agent of the State Medical Society. Renegotiation of the present agency contract between the State Medical Society and Blue Cross is just getting under way as this report is written. Such a renegotiation becomes essential from time to time as the functions of the agent change and as the program itself changes.

Because the insurance companies do their own drafting and handling of claims, the legal work in connection with the new Wisconsin Plan contracts is understandably much more limited in volume, but is important to the public and profession. It consists primarily of analyzing all policies, riders, and advertising literature to assure their consistency with the specifications adopted by the Commission in December 1951. It also entails conferences with the staff and correspondence with insurance companies, patients, and physicians who raise questions relating to the Wisconsin Plan.

The legal aspects of the programs are thus seen to be an integral part of the planning, the administration, and the research which is essential to sound growth. The law does not operate in a vacuum, but cross sections practically all other activities and functions of the plan. While it is true that legal technics are summarized and evidenced in the written word, the background and source of the written word lie in this instance in the day-to-day contact of the plans' legal advisors with the known or anticipated problems of developing or operating such plans and working for their improvement.

Claims

In the period from July 1, 1951, ending June 30, 1952, Wisconsin Physicians Service handled a total of 41,389 claims involving a total of $1,738,815 paid to physicians. The average cost per case was $42.01 and the average cost per procedure was $33.73.

The 41,389 cases above mentioned involved 51,556 procedures as follows:

	Procedures	Amount	Average Cost Per Procedure
Surgery in the hospital	25,116	$1,169,487.00	$46.56
Surgery in home or office	7,008	77,377.50	11.04
Medical care in hospital Medical days paid—46,607	9,401	139,821.00	14.87
Deliveries	5,198	311,759.00	59.97
Anesthesia and x-ray	4,833	40,370.50	8.35
Total—12 months' period	51,556	$1,738,815.00	$33.73

It is interesting to note that May and June of 1952 produced the highest number of cases and the largest amounts paid to physicians for any particular period during the past year.

Cases were rejected for such reasons as incomplete waiting periods, pre-existing conditions, cases covered under Workmen's Compensation, exclusion of maternity benefits from the contract, procedures excluded by riders, contract cancelled, claims made for ineligible dependents, Veterans Administration responsibility, state institutions, and surgery-only contract. The handling of rejections is in itself expensive, more so upon occasion than a valid claim.

A new Physicians Service Report blank is being used on an experimental basis to improve the reporting method and to facilitate payment of benefits. Good cooperation has been received from physicians, clinic managers and physicians' office employees. By the first of the year the trial PSR will be sufficiently tested so that a revised and standardized procedure can be developed.

The Claims Committee consists of three physicians who are members of the Commission. It meets with sufficient regularity to keep current on the problem cases and to instruct the staff. The Commission and staff are also advised by the medical director, who reviews the complicated claims.

The Claims Committee has completed a master fee schedule used by the staff in the payment of unlisted procedures. The Commission on Prepaid Plans emphasizes that it becomes important to physicians that as many procedures as possible be retained in the unlisted and unpublished schedule. While such schedule represents a large total, the items listed are not individually a substantial total in claims paid. Thus, as inequities arise or new procedures become accepted, it is possible to make adjustments without contract and published schedule revision.

The Commission emphasizes that the Claims Committee is, of necessity, one of its hardest working units. Generally meeting as often as three or more times each month, its individual members are frequently consulted between times on matters that should not be held until a scheduled meeting. The membership of the committee must be conversant with contract provisions of the plans, and frequently avails itself of the advice of other physicians as well.

The Commission feels that the record of the Claims Committee speaks well for its industry and its careful and effective consideration of the many and difficult problems it encounters.

How WPS Statistics Are Now Maintained

Effective July 1, 1952, Wisconsin Physicians Service began to prepare and maintain its own claims paid statistics at the Madison office.

By taking over many of these functions the Commission has greatly simplified the preparation of checks, obtained an increased number of statistical studies for rate making and general administrative purposes and lessened the burden on Blue Cross which resulted from growing need for utilization statistics.

Some of the uses to which the statistical records will be put include:

1. Detailed income and claims paid records on individual groups with 200 or more subscribers, which represents 30 per cent of all subscribers. This record is required to properly analyze these groups for the purpose of the Merit Rating Program.

2. Semi-annual and annual reports will be required by the actuary to properly evaluate the Wisconsin Physicians Service rate structure and to insure its soundness.

3. Monthly reports are required to furnish financial information for entry on the books of Wisconsin Physicians Service. The estimated monthly utilization is determined by use of statistical reports as is WPS liability for unreported claims.

4. The National Blue Shield Commission requires monthly, quarterly and annual reports from its member plans.

5. Individual groups presenting special situations are studied on an individual, and often on a monthly basis, making necessary another type of statistical study.

6. Each participating physician is informed annually as to the amount received by him in the form of service benefits. This is necessitated by state and federal income tax laws.

7. As particular trends are noted, other studies can be prepared to assist in analyzing and interpreting patterns which seem to be forming and may be of substantial consequence.

8. Many statistical studies in addition to the above are prepared for use in daily administration.

Increased Utilization

The first six months of 1952 showed utilization considerably higher than normal, due to the following reasons, among others:

1. *Increased Home and Office Surgery Benefits.* Prior to July 1, 1951, benefits for home and office surgery in the WPS contracts were limited to those necessitated by accidental injury. Statistically, these benefits have shown a

marked increase the past year. Effective July, 1951, the contract with respect to home and office surgery was liberalized, without increase in rate, to provide benefits for any such surgery, regardless of whether necessitated by accidental injury. The following figures disclose the growth of this type of coverage:

Emergency home and office surgery, 1/1 to 6/30/51		$13,398
Emergency home and office surgery, 1/1 to 6/30/52	$24,798	
Additional home and office surgery benefits due to liberalization, between 1/1 and 6/30/52	19,562	44,360
Increase first half 1952		$30,962

The above increase of $30,962 in home and office surgery over the similar period of 1951 represents about 2½ per cent of earned income the first half of 1952, and slightly more than 3 per cent of the dollar value of all claims paid.

2. *Blue Cross Comprehensive Coverage.* The full effect of the introduction by Blue Cross of its Comprehensive Contract doubtless accounts for some increased utilization experienced by Blue Shield. The first half of 1951 did not see the full utilization of the broader benefits provided by Blue Cross contract. There was a substantial changeover of subscribers to the new coverage during the year and a half ended June 30, 1952. As a result the people covered have become more fully aware of the increased benefits available and are using them. This is further substantiated by the increased claims and loss ratio experienced by Blue Cross in the first six months of 1952. These developments quite naturally affect all combined Blue Shield–Blue Cross installations.

3. *Increase in Claims Paid for Orthopedics, Fractures, and Dislocations.* The first six months of 1952 showed an increase in claims paid for these procedures. This may be due, in part, to more highway accidents during the past winter and a slightly higher incidence of other forms of accidental injury requiring hospitalization.

4. *Reduced Enrollment.* Wisconsin Physicians Service increased its membership by only 7,722 contracts during the first six months of 1952. Thirty-six per cent of this increase was in single contracts, the other 64 per cent in family coverage. New subscribers, not fully aware of how to utilize their coverage to the fullest extent, provide part of their subscription rate to carry the load of "aged" coverage which shows a heavier utilization pattern. Because of the small increase, the cushion usually provided by new subscribers was not as large as in the past. This accounts for part of the higher loss experience during the period. See Chart I.

5. *Increase in Tonsillectomies and Adenoidectomies.* A substantial change is demonstrated in utilization in the first six months of 1952 against similar periods in prior years. In comparison with the first half of 1951, the percentage of incurred claims to earned income rose in 1952 from 75 to 83. Reasons outlined in preceding paragraphs explain a large part of this increase, but emphasis must be given the incidence of tonsillectomies and adenoidectomies, which showed a 32 per cent increase and explains one-fourth of the dollar value of the rise in claims the first half of 1952 as contrasted with the same period of 1951.

* * *

Because of the necessity for reporting utilization promptly after the close of a given period, the last few months of the period being reported are subject to final correction of the estimate of incurred claims.

None of the reasons given above, when considered alone, is sufficiently significant to account for the increase in utilization. However, when taken as a group, along with other reasons known and unknown, they provide a fairly complete picture of the changes taking place.

There follow charts which summarize major experience of Wisconsin Physicians Service in recent months.

The first, entitled "Enrollment Progress," is believed self-explanatory, showing as it does the growth of the plan in terms of single and family contracts as of the close of each year of the plan's operation through 1951, and the growth the first half of the current year.

The second chart, entitled "Analysis of Claims Paid," covers only the first half of 1952. The left half shows the major procedures in terms of their frequency, expressed in thousands. The right half shows graphically the dollar cost to the plan, expressed in thousands, for the same procedures.

COMPARISONS OF UTILIZATION DURING FIRST SIX MONTHS OF 1952

	Earned Income	Incurred Utilization	Per cent of Utilization
January 1952	$ 193,670	$161,638	84%
February	194,206	154,457	80%
March	200,243	156,401	78%
April	202,905	169,580	84%
May	202,266	174,196	86%
June	208,055	178,418	86%
Total First Six Months	$1,201,345	$994,690	83%

For First Six Months of—	Earned Income	Incurred Utilization	Per cent of Utilization
1948	$ 266,739	$208,836	78%
1949	568,097	448,964	79%
1950	792,662	618,985	78%
1951	1,029,215	775,377	75%
1952	1,201,345	994,690	83%

CHART I

ENROLLMENT PROGRESS

1947–1952

Year	Single Contracts	Family Contracts	Contract Totals	Total Persons Covered
1947	8,137	11,091	19,228	45,378
1948	17,590	25,599	43,189	101,926
1949	25,464	39,580	65,044	155,751
1950	33,951	53,191	87,142	209,757
1951	37,403	61,559	98,962	240,296
June 30, 1952	40,157	66,527	106,684	259,244

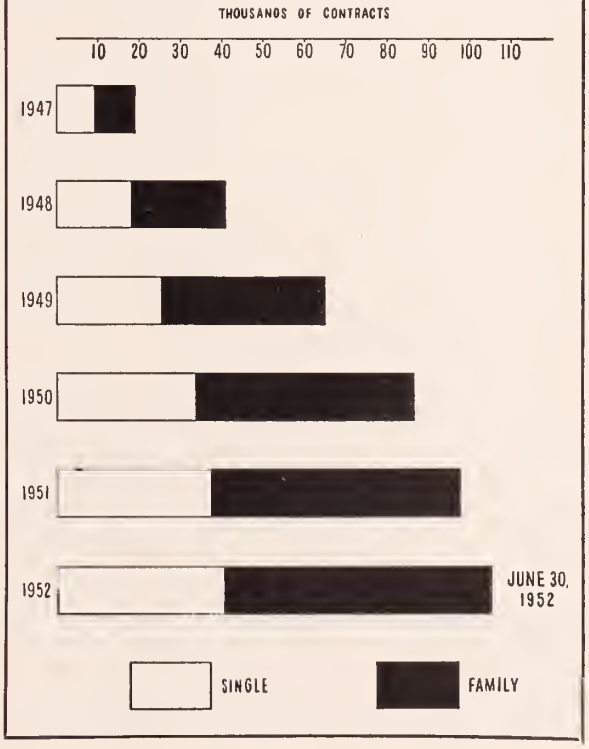
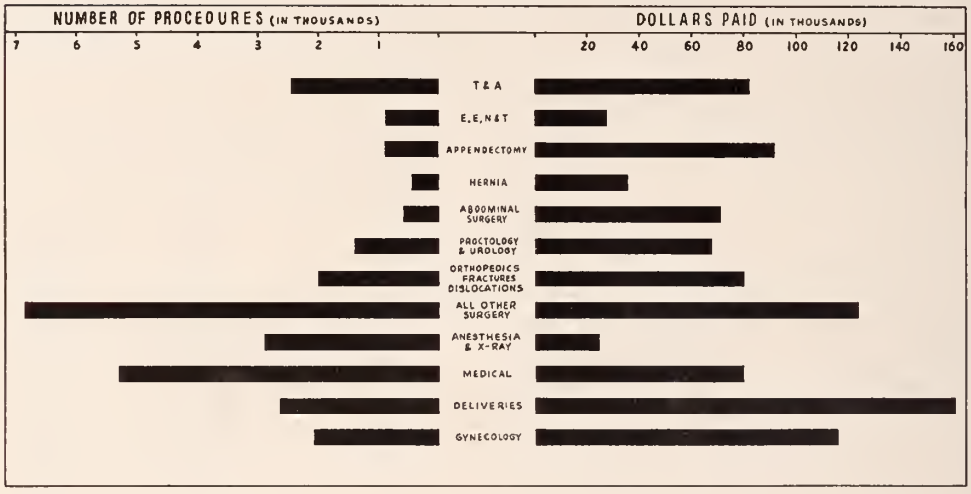


CHART II
ANALYSIS OF CLAIMS PAID
During First Half of 1952



Publicity and Public Relations

Activities in this field fall into two specific categories, one the promotion of the program through publicity, descriptive material, and advertising, and the other in general service to medical societies, lay groups, and field service.

In connection with general promotional activities, more than $10,000 has been expended to provide newspaper advertisements, exclusive of Milwaukee County, in daily and weekly publications in order to provide not only a general announcement of the new WPS program, but to "pave the way" for change-over of existing business, and in particular, to develop interest on the part of existing business in order to lessen the resistance to increased price.

In addition to efforts along the lines just indicated, a mail campaign has been directed to all existing groups having coverage under WPS contracts, as well as to more than 5,000 groups which have evidenced interest in the WPS program. As the members appreciate, communications have been directed on repeated occasions to all physicians, to notify them of time tables, changes, participation panels, new PSR, and other procedures. Mechanisms have had to be devised in order to assure that a group now covered has adequate notice of the fact that that coverage expires at the time of the anniversary date of its contract, and that the group must determine whether to accept the "A" or "B" schedule, or a combination of them, or cancel.

Other problems presenting particular difficulties involve those who hold individual contracts which require that individual mailings be sent each such person with adequate notice that the old program is being discontinued and that the individual has the same option as provided under group coverage. Some newspaper publicity has been obtained, but not on any extensive basis.

In addition, information is being made available through the Wisconsin Medical Journal, and devices have now been established to inform the medical profession locally of those groups installing the new program and of their location. Regular Commission letters will be distributed to the entire membership as well as to hospital superintendents and other interested groups to keep such individuals fully informed as to pending developments and actions of the Commission itself.

In addition, field service is being rapidly developed so that during the ensuing year area conferences may be held with employees of physicians not only to provide them with background information as to the purpose and effect of the voluntary plans, but to illustrate the administrative machinery and the extent to which alertness on the part of employees of physicians to the specifications of the program may more adequately serve the interests of their employers —the physicians. Several such conferences have been held on a trial basis and they have enjoyed a considerable measure of success and interest.

All matters of general promotion, public relations, and relations with physicians must be handled to some degree, and sometimes largely, in conjunction with Blue Cross, as each has interrelated responsibilities and interests in the work of the other in these several fields. To illustrate, a Society staff representative will attend, during the fall of 1952, hospital administrative staff conferences arranged by Blue Cross to serve a somewhat comparable purpose to those being arranged by the Commission with physicians and physician employees.

This marks a high degree of cooperation that should serve the ultimate good of the plan, the participating physicians, the hospital, and the patient.

Accounting

Because the meeting of the House of Delegates is scheduled in early October, it is not possible to supply it with WPS financial reports for the full year. Therefore, the Commission feels that at the time of submitting the report for general distribution to the House, it is best to provide the first six months of the current year, and the same period of the previous year.

There follows a comparative statement of income and expenditures for the first six months of 1951 and the first six months of 1952, and the balance sheet as of June 30, 1952.

Activities of Consulting Actuaries

During the past year the firm of Carl A. Tiffany & Co., consulting actuaries, has served the Commission on Prepaid Plans and the State Medical Society staff as technical advisors in the preparation of the new WPS program, which became effective on July 1, 1952. They assisted in the drafting of the various contract forms and established the premium rate structure.

The WPS premiums recommended by the actuaries were based on a statistical analysis of WPS experience during the period July 1, 1949 through June 30, 1951. Detailed studies were made of the claims incurred during this period. Analyses of the claims were made as to type of contract, sex and dependency status, length of exposure at service date, type of surgical procedure and number of medical days. Group experience was also considered by classes as to type and size of the groups.

The WPS experience was then compared with the experience of other Blue Shield plans and commercial companies to properly evaluate the reliability of the WPS statistics.

WISCONSIN PHYSICIANS SERVICE
Madison, Wisconsin
BALANCE SHEET
June 30, 1952

Assets		
Cash on Hand and in Banks		$ 284,816.83
Cash on Deposit with Agent		121,000.00
Due from Agent		36,057.50
Refunds Receivable		1,582.50
U. S. Government Bonds—Net	$795,884.20	
Accrued Interest Income	429.18	796,313.38
Office Furniture and Fixtures—Net		13,338.87
Unexpired Insurance		496.12
Other Deferred Expense		1,032.71
Total Assets		$1,254,637.91
Liabilities and Reserves		
Accounts Payable		$ 5,247.55
Accrued Expenses		6,428.71
Physicians' Claims Payable		233,806.36
Unearned Income		232,573.48
Advances—State Medical Society of Wisconsin		29,000.00
Reserves—		
Maternity Benefits	$148,500.00	
Disaster Claims	114,799.00	
Unforeseen Contingencies	283,073.77	
Administrative	187,242.38	
Investment	13,966.66	
		747,581.81
Total Liabilities and Reserves		$1,254,637.91

WISCONSIN PHYSICIANS SERVICE
Madison, Wisconsin
COMPARATIVE STATEMENT OF INCOME AND EXPENDITURES
For the Periods January 1 to June 30, 1951 and 1952

	1-1-1951 to 6-30-1951	1-1-1952 to 6-30-1952	Increase or (Decrease)
Income			
Earned Premium Income	$1,029,215.49	$1,201,344.37	$172,128.88
Investment Income	2,291.14	6,362.76	4,071.62
Total Income	$1,031,506.63	$1,207,707.13	$176,200.50
Expenditures			
Physicians Claims	$ 768,674.44	$ 994,690.25	$226,015.81
Expenses of Agent	92,465.41	113,089.28	20,623.87
Salaries	21,794.93	37,358.37	15,563.44
Legal Expense	2,621.11	4,615.03	1,993.92
Auditing Expense	3,047.96	4,992.75	1,944.79
Actuarial Expense	325.44	5,479.88	5,154.44
Conference Expense	2,163.06	5,566.66	3,403.60
Staff Travel	858.08	1,410.76	552.68
Stationery and Supplies	2,394.61	4,676.86	2,282.25
IBM Rentals and Supplies		110.25	110.25
Rent	1,828.50	3,402.00	1,573.50
Office Expense	726.53	951.43	224.90
Postage and Express	1,636.62	1,998.68	362.06
Payroll Taxes	669.36	963.81	294.45
Telephone and Telegraph	1,799.56	3,238.85	1,439.29
Employees Group Insurance	298.20	450.40	152.20
Depreciation	455.36	691.51	236.15
Insurance	211.24	207.52	(3.72)
Association Dues	1,315.56	1,495.25	179.69
Other Administration Expenses	29.27	178.09	148.82
Total Expenditures	$ 903,315.24	$1,185,567.63	$282,252.39
Available for Reserves	$ 128,191.39	$ 22,139.50	($106,051.89)
Disposition of Income, Dollar			
Physicians' Claims	$ .75	$ .82	$ .07
Expenses of Agent	.09	.09	------
Other Administrative Expense	.04	.07	.03
Addition to Service Benefit Reserves	.07	—.01	(.08)
Addition to Administrative Reserve	.05	.02	(.03)
Addition to Investment Reserve	----------	.01	.01
Totals	$ 1.00	$ 1.00	$----------

Studies made by the Actuarial Society of America were also used in these comparisons.

After a comprehensive review of the WPS experience, the actuaries presented the rate structure which they believe will accomplish the following objectives:

1. Provide coverage to as many as possible at reasonable rates.
2. Be competitive in order to prevent adverse selection.
3. Maintain a sound financial structure for WPS.
4. Provide stability of cost to the participants.

In order to accomplish these objectives it was recommended that the group business be divided in three principal classes. A basic rate was quoted to cover groups which are considered to be "substandard." An intermediate rate was established for standard or average risks. For the better than average risks an initial rate was quoted; however, these groups would participate in a merit rating program. New rates were also computed for the group conversion and nongroup contracts.

The actuaries have also assisted the staff in many other phases of the new WPS program. They have helped develop a statistical program for WPS which will in the future provide adequate information for the proper evaluation of the WPS operation. New enrollment and underwriting regulations were prepared in cooperation with the Blue Cross staff. The actuaries have met with the Blue Cross staff many times in order to bring about more complete understanding of the WPS program. As the conversion of the WPS subscribers to the new program progresses, new problems arise which require the services of the actuaries. They have also been engaged in the renegotiation of the Blue Cross agency contract.

The Research and Development Committee and the Enrollment and Underwriting Committee have referred several projects to the consulting actuaries for study. The results of those studies should provide WPS with further improvements in its program of prepaid medical care for the people of Wisconsin.

Conclusion

This report is prepared near the close of August, and various statistical reports will be subject to some modification within a month. The impression of the Commission is that the new plans are off to a good start. Conversion of old WPS coverage to the new plans and new sales indicate that on September 1, 1952, total coverage under the new plans will approximate 20,000 persons. Enrollment in the Wisconsin Plan written pursuant to the new specifications is probably substantial although no reports have as yet been asked by the Commission.

Vital to the growth of both, and the key to their success, is the physician and his support of their social advisability, their public health desirability, and their part in the over-all movement to prevent a socialized America.

ON BEHALF OF THE COMMISSION ON PREPAID PLANS BY ITS EXECUTIVE COMMITTEE:
E. M. DESSLOCH, M.D., *chairman,* Prairie du Chien
H. E. KASTEN, M.D., Beloit
J. S. SUPERNAW, M.D., Madison
ROBERT KROHN, M.D., Black River Falls

With action completed by the House of Delegates in the fall of 1951, instructing the development of Wisconsin Physicians Service and policies of the Wisconsin Plan to include full-payment benefits to two different income levels, and with the use of two different schedules, the administrative organization of the State Medical Society was developed rapidly to carry out this mandate.

The reference committee felt that the Commission is to be commended for the comprehensive character of its report, and deserves the appreciation of the Society as a whole for the industry and foresight which have gone into planning for this past year.

The attention of the House is invited to the inevitable complexities which attend a changeover to the program of two income levels during a period when the old program

also remains in force, and thus in the administration of three separate programs. The number of claims has substantially doubled within the past 15 months, and physicians are asked to be patient and to continue the fine cooperation which has been given so far.

The basic soundness of the thinking out of which the Wisconsin Plan was developed several years ago, is indicated by the decision of 11 insurance companies to offer the new program, despite its much higher requirements and demands under new specifications. It should be noted in passing that those 11 companies have each prepaid $500 toward the estimated cost to the State Medical Society in administering this program during the year ending June 30, 1953.

From a reading of the report of the Commission it is evident that the present program of the Medical Society of this state has at least two distinguishing characteristics. The first is the determination of the Commission that emphasis be on quality rather than size. To this end it has inaugurated and is in the process of making additions to a program of self analysis, which goes on at all times with reference to Blue Shield. This is made possible through actuarial and accounting advice from the outside, and from a statistical service within the program, which is under the continuing supervision and guidance of these consultants.

The other distinguishing mark is the concern of the Commission with the future of the program, and with its place in the practice of medicine in the years ahead. Developmental work is going on at the present time in the fields of catastrophic coverage and of indemnity insurance, the latter to be available primarily to individuals and groups whose incomes are in excess of full payment limits. The problem of conservation or retention of coverage in good times and bad is also receiving careful study.

The reference committee recommended that the Council and the Commission receive the high commendation of this House of Delegates.

On motion of Doctor Kasten, seconded by Dr. Charles W. Giesen, Superior, carried, this section of the report was accepted.

Report on the Student Loan Fund

The reference committee heartily endorsed the report on the Student Loan Fund, presented to the House at its first session by Dr. H. H. Christofferson. It recommended that the resolution proposed by the Council in this respect be approved.

On motion of Doctor Kasten, seconded by Dr. J. W. Fons, Milwaukee, carried, this section of the report was accepted.

Council on Medical Service

D. E. Dorchester, chairman; R. L. MacCornack; C. G. Reznichek; T. D. Elbe, L. O. Simenstad; Maurice Hardgrove; T. E. Gundersen; D. M. Willison; D. N. Goldstein

One year ago the House of Delegates consolidated the Council on Medical Service and Public Relations and the Committees on Rural Health, Public Instruction, Industrial Health and Open Panels with the responsibility for the work of these committees assigned directly to a new Council on Medical Service. It is a pleasure to report that this Council has functioned effectively in the interest of the Society during its first year.

Medical-Press Conferences

During the spring and summer of 1952 this Council conducted a series of Medical-Press Conferences at Sheboygan, Madison, Appleton, Wausau, La Crosse, and Superior. Invitations were extended to all physicians, hospital administrators, newsmen from newspapers and radio stations, police officers, sheriffs, and clinic managers in the areas around the conference cities. Total attendance reached more than 500. The conferences were conducted in the evening with a minimum of formal speeches and a maximum of free and open discussion. The program pattern at each conference was the same:

1. Invitation to Discussion—Physician Chairman
2. News is Our Profession—Newsman
3. Doctors and Hospitals in the News—Physician
4. Open Discussion
5. Snack Period

Following each conference, an opinion summary was sent to every person in the area who was invited. In this way, the summary of the conference was reported to more than 2,000 persons who did not attend the conferences, as well as the 500 persons who did.

Out of this series of conferences, the Council feels there have come at least seven well-defined areas of need or expression of problems:

1. Newsmen do not always know or appreciate the importance of the physician-patient relationship as it affects or is affected by the dissemination of news. The physician can never break the confidence of his patient without the patient's consent. The diagnosis or prognosis may in truth be unknown or uncertain during the early hours of an accident or illness, and the insistence of newsmen for an immediate statement may well cause irritation.

2. Physicians and medical societies should establish a pattern for clearing information on news of accidents or illness. Physicians must recognize that newsmen have deadlines to meet, and seek to end the merry-go-round of telephone calls that often results from a newspaper seeking information on the condition of an accident victim. A general suggestion was for the establishment of a brief card system in every hospital, on which the physician could indicate information which could be released to the press. The importance of the hospital in the medical-press relationship cannot be overemphasized.

3. Stories of new drugs and treatments have high readership, but physicians feel that many are premature and poorly prepared. By and large, local newsmen in Wisconsin have little to do with their preparation. The stories originate on the wire services. The American Medical Association is working closely with science writers on many such stories, but a large number are published without benefit of medical authentication or interpretation. Newsmen are most anxious that local medical societies establish panels of physicians who can be contacted whenever the press or radio has a medical story on which it wants to check the authenticity or availability of the drug or treatment.

4. Physicians and newsmen alike are not fully cognizant of the laws pertaining to violation of confidence in private practice and the availability of public records to the public, including newsmen. There is widespread recognition that certain public health records are confidential, such as the names of those having venereal disease, but there is considerable uncertainty as to whether other records are open for public inspection and publication. Newsmen find medical terminology confusing and unintelligible from the layman's standpoint.

5. Weekly newspaper editors and small-town radio stations have few problems with medical and hospital people,—first, because there are fewer persons involved and time limits are not so pressing; and second, because they usually are personally acquainted and discuss their mutual problems freely.

6. In cities with one or more large hospitals and several newspapers and radio stations, the need for frequent conferences between the press and physicians is evident. There was not sufficient time in the early spring and summer to conclude the series of area conferences, and the Council recommends that conferences be held in the Milwaukee, Racine–Kenosha, and Prairie du Chien areas as soon as possible. The Council further recommends that county and district medical societies in the areas where conferences have already been held continue these conferences on a local basis. The Council is also giving thought to the establishment of an annual state-wide conference in this field.

7. There is obvious need for the preparation of a manual or a guidebook for the use of physicians, hospitals, newsmen in both newspaper offices and radio stations, sheriffs and police departments, and schools of medicine and journalism. Such a manual should include a glossary of terms

frequently used by medical men in describing the condition of patients and the nature of a particular disease or treatment; the physicians' code of ethics; an interpretation of the doctor-patient relationship as it affects the dissemination of news; a review and explanation of the laws pertaining to confidential public records; and suggestions for the establishment of improved working relationships between the doctor, hospital, and newsman.

The enthusiastic response to these conferences, particularly from physicians, daily and weekly newspaper editors, and radio station personnel, in the opinion of the Council on Medical Service, has been a significant forward step in medicine's public relations. Improved public health is the goal of men in both professions. Physicians and newsmen must continue to recognize each other as equally important professional groups. The Council on Medical Service believes that these conferences will help them find a basis for mutual trust and understanding that will work to the benefit and protection of the public as well as to their own advantage.

Rural Health

Through the continuation of the rural health program of the State Medical Society the Council on Medical Service has sought to improve the rural dweller's understanding of his responsibility for better health, and to assist in improving their own health by working together through community organizations.

The annual Wisconsin Rural Health Conference, sponsored by the State Medical Society in cooperation with nearly 55 farm, health, and governmental agencies and organizations, is now widely recognized among Wisconsin farm people as providing leadership for rural health programs and activities.

Your Council wishes to report that more than 350 farm and health leaders attended the 1951 conference at Stevens Point. Problems of safety, nutrition, sanitation, mental health, care of the aged, and health insurance were explored. Not only has this conference influenced many individuals and farm groups to improved health programs, but the effects of the Society's leadership at the conference are felt throughout the year in the appeals of farm organizations and rural youth and adult leaders to the Medical Society for assistance in the development of their health programs and the solution of their health problems.

Despite the success of the second annual Rural Health Conference, the Council on Medical Service and the Executive Committee of the conference were agreed that the travel and expense occasioned by a single state-wide meeting were undoubtedly responsible for the fact that many local county leaders and practicing physicians were absent from the conference. In an effort to make the conference more readily available to all the people of Wisconsin, the third annual conference will be regionalized with one-day meetings to be held in Green Bay, November 13; Madison, November 14; Eau Claire, November 18, and Wausau, November 19. The arrangement is similar to that used by the well-known postgraduate teaching circuit. The program will stress home safety, safe water and milk, immunization, and city-county health departments. Farm organization leaders, homemakers, 4-H Club leaders, county agents, and public health nurses are most enthusiastic about the possibilities of the area meetings. This arrangement will place the conferences within easy reach of the medical profession. Your Council believes that medicine's position in rural Wisconsin will be greatly strengthened if physicians from every county medical society attend the conference with local farm leaders and participate in the discussion meetings. The attendance and participation of physicians are vital if the solutions of rural health problems are to incorporate accepted principles of good medical practice.

Last February, the Council prepared and presented a successful rural health program as part of the annual Farm and Home Week of the College of Agriculture of the University of Wisconsin. This is the third consecutive year that the invitation has been extended to the Medical Society to present this section. A special half-day program on heart disease and rheumatic fever drew a large crowd and much attention. The Society presented an exhibit on "Animals in Research" which was recognized as one of the most attractive at the entire Farm and Home Week program and was so widely visited that more than 8,000 pamphlets on cancer, care of the aged, and health insurance were distributed over a four-day period.

During 1952 your Council has continued to expand its relationship with the Extension Division of the University of Wisconsin and the 4-H Club program in Wisconsin. Those responsible for the development of the 4-H Club health program throughout the state have seen fit to invite a representative of your Council to the annual program planning meeting for 4-H Clubs. In addition, the state 4-H leaders have requested an opportunity to hold their annual session at the Wausau Rural Health Conference this fall. At the same time, 10 or 15 outstanding state 4-H Club leaders will attend the Wausau Conference under the sponsorship of the State and county medical societies. The State Medical Society annually makes $100 available for the purpose of sponsoring several individuals to the annual 4-H Club health camp. This health camp has been discontinued in favor of the leadership program at the Rural Health Conference in the belief that this will produce more continuing results. Several county societies, which have previously sponsored young people to the annual 4-H Club health camp, will be asked to sponsor 4-H Club leaders as an alternative. In addition, the State Medical Society provides a $100 scholarship to an outstanding 4-H Club boy or girl who has been responsible for developing a successful community health project during the past year. This scholarship is used to send the person to the annual 4-H Club convention in Chicago.

Your Council continues its work with the Extension Division and the county homemakers particularly through the provision of health education materials and speakers for homemakers' meetings. Health problems and projects have recently become important in the programs of the county homemakers group, and they are extremely desirous of having physicians participate in their meetings. Medical societies are encouraged to provide suitable guidance at the 4-H Club and homemaker level wherever it is requested.

The March of Medicine

The Council is happy to report that on April 1, 1952, "The March of Medicine" began its seventh consecutive year of broadcasting under the direction of the State Medical Society. Most encouraging is the fact that 32 radio stations in Wisconsin, one in Michigan, and one in Minnesota now present this program each week as a public service feature. This is an increase of seven stations since the 1951 report.

WHBY, Appleton
*WHKW, Chilton
*†WHWC, Colfax
*WHAD, Delafield
WEAU, Eau Claire
KFIZ, Fond du Lac
WBAY, Green Bay
*WHLA, Holmen
WJMS, Ironwood, Mich.
†WCLO, Janesville
WLIP, Kenosha
WKBH, La Crosse
WLDY, Ladysmith
*WHA, Madison
WIBA, Madison
WOMT, Manitowoc
WMAM, Marinette
WDLB, Marshfield
WIGM, Medford
WEMP, Milwaukee
†WEKZ, Monroe
WNAM, Neenah
WOSH, Oshkosh
†WIBU, Poynette
†KAAA, Red Wing, Minn.
WOBT, Rhinelander
*WHRM, Rib Mountain
WJMC, Rice Lake
WRCO, Richland Center
WHBL, Sheboygan
*WLBL, Stevens Point
†WDOR, Sturgeon Bay
†WDSM, Superior
WSAU, Wausau

* On WHA chain, also carried on FM.
† New since 1951 report.

During 1951 the Society began offering stations a new type of presentation which featured an interview between Dr. Robert C. Parkin and Paul Davis, a medical reporter. This interview-type program has met with such favor from radio stations and listeners that it is now used exclusively.

All programs are recorded on tapes rather than on records, a fact which simplifies shipments and materially reduces the cost of furnishing these broadcasts to the stations. A significant increase in fan mail has occurred during 1952. Despite the summer "slump" experienced by any radio show, fan mail for 1952 has more than doubled the correspondence received in 1951. During the peak months, nearly 500 requests are received for copies of the scripts or health information.

It is interesting to note that about two-thirds of the fan mail comes from persons living in towns, villages, and cities and about one-third of the fan mail comes from persons actually residing on farms.

Your Council is satisfied that the new type of interview program and the expanded coverage afforded by 34 radio stations provide one of the most important health education mechanisms ever available to the people of Wisconsin. The nature of the fan mail and the approval of the radio station managers indicate that the program is achieving its goal.

The Council recognizes, however, that the Society should always seek an expanding listening audience for the program and consequently believes that the State and county medical societies and the Woman's Auxiliary to the State Medical Society should make every effort to encourage a wider listening audience, particularly among women's groups.

Physician Placement Service

For the past several years the State Medical Society has carried on a physician placement and location service as an integral part of the Society office functions. Because of its importance and its expansion to the point where greater direction needed to be given to this activity, the Council on Medical Service has assumed direction of this program. Through the Physician Placement Service, any physician in Wisconsin may seek assistance in obtaining a locum tenens, associate or practicing physician under any type of arrangement. Likewise, communities seeking the services of a full-time physician may present their request, and every effort is made to bring this opportunity to the attention of physicians seeking locations.

Close contact is maintained between the University of Wisconsin Medical School and Marquette University School of Medicine so that physicians completing internships and residencies have every opportunity to review locations available to them. A list of physicians seeking locations is kept up to date, and each month they receive a list of the locations which are not yet filled. Likewise, a community desiring a physician is sent the names of physicians seeking a location in a community of that particular size.

Although turnover is considerable at all times, there is an average of about 30 available locations as well as physicians seeking locations. When a community requests that it be placed on the list of available locations, the Society office sends the contact person in the community a detailed questionnaire which is filled out and returned to the Society office. There it is available for review by any interested physician. The questionnaire contains information concerning population, present supply of professional services, types of industries and business, educational facilities, hospital facilities, housing, churches, communication facilities, and details of any special arrangements the community is willing to make with the physician. At the same time the community is sent a packet of informational material and bulletins concerning what a doctor looks for when he wants to set up a practice and what a community can do to encourage a physician to settle there.

In several instances throughout the past year the president and president-elect of the Society have filled requests to speak at community gatherings where the subject of obtaining a physician was under discussion. These meetings have been most productive of good will, and it is believed they should be encouraged and continued wherever the situation warrants.

In conjunction with the American Medical Association and the Armed Forces, the Physician Placement Service is contacting all physicians who have indicated a desire to locate in Wisconsin on being released from active duty. Information is sent to these physicians as soon as it is learned they are about to leave service. They are given the list of available locations and offered the services of the Society in helping them to locate and establish their practice. The Council believes this is an activity of the highest value to the profession.

Health Information and Education

During the past year the Council on Medical Service has developed several special projects in the field of health education.

A first-aid chart, utilizing cartoons, was developed and printed by the Council. This chart has been enthusiastically received by county superintendents of schools, and 4-H Club and county homemaker leaders throughout the state. It is available at a cost of $3 per hundred. The Council feels that this chart fills a very vital need because there have been repeated situations in which the unavailability of simple first-aid instructions has hampered the adequate medical care of accident and illness victims.

Since January, all radio stations in Wisconsin have received a bi-monthly bulletin from the State Medical Society known as "Health Spot Announcements." These spot announcements are broadcast by the radio stations as a public service feature and include health information of current interest to radio listeners. New developments in medicine, as well as timely health suggestions, are incorporated in these releases. The spot announcement service was established after inquiries were sent to every radio station. The comments were so enthusiastic that the program was instituted immediately and has been widely used by many stations throughout the year.

Also, during the past year a health news service has been established for the house organs and company publications of more than 300 industrial firms in Wisconsin. These two-page news releases cover one health subject in some detail and include a summary of interesting "Health Facts and Fallacies." These releases are widely used by house organ editors, and in some instances as many as 75 copies are sent to various firms for posting on their company bulletin boards.

Loan packets to students and other individuals and organizations continue to be an important public relations activity under the Council's direction. Literally hundreds of these requests are received by the Society office each year on a wide variety of subjects. Socialized medicine and voluntary health insurance continue to be subjects of considerable interest and form the bulk of informational packets provided. A large number of students have used the materials as a basis for their class projects, and many gratifying letters have been received as a result of the Society's efforts in this field.

Of particular interest to the House of Delegates will be the development of a special issue of the bi-monthly bulletin of the State Board of Health known as "Health."

The September–October issue of this bulletin was devoted entirely to the program and activities of the State Medical Society with articles written by officers and committee members of the Society. More than 12,000 copies of this issue were distributed to Wisconsin people, and reprints are being used to supply persons who inquire about the activities of the Society.

Industrial Health

The Committee on Industrial Health of the Council on Medical Service has concerned itself with three important activities during the past year.

1. *Industrial Health Clinics:* Following the program of in-plant clinics which have proved so successful in Wisconsin during the past six or seven years, the Committee on Industrial Health sponsored three highly successful meetings.

a. *Miller Brewing Company,* Milwaukee: Attended by more than 300 physicians, industrial nurses, and plant management representatives. A scientific program was conducted in cooperation with the Central States Society of Industrial

Physicians and Surgeons, the Industrial Hygiene Unit of the State Board of Health, the Wisconsin Nurses Association, and the Industrial Health Committee of the Medical Society of Milwaukee County. The all-day scientific program consisted of a clinic on "Salvaging the Injured Hand," and a discussion on older workers in industry, hearing problems related to industrial environment, and an outstanding symposium on "Women in Industry."

b. *U. S. Rubber Company,* Eau Claire: Presented in cooperation with the local county medical society, the State Nurses Association, the State Board of Health, and the U. S. Rubber Company. More than 100 physicians attended. The program stressed hand surgery, rehabilitation, and dermatitis.

c. *Nash Motors,* Kenosha: Over 140 physicians, nurses, labor leaders, and management representatives were in attendance, under the same type of sponsorship as the clinic in Eau Claire. The scientific program featured rehabilitation and the cardiac in industry. Outstanding discussions on the older worker and conserving the younger executives were presented as the after-dinner program.

The entire program in 1952 was well received and will be continued on the same general basis in 1953. Milwaukee will be one of the teaching sites and other clinics will be held in smaller communities where industrial practice is largely the function of the general practitioner.

The cooperation of the State Board of Health in this program cannot be over-emphasized. Practically all of the attending costs are underwritten out of funds supplied the State Medical Society through the Industrial Unit of the State Board of Health. Thus, physicians are deriving benefit from these programs without any direct cost from the State Society treasury, other than the time of the staff in preparing promotional material, handling reservations, and arranging details of the meetings.

2. *Special Problems of the Migrant Worker:* Many areas of the state are concerned, medically speaking, with problems related to the migrant workers who come into the state under work contracts from the West Indies and Mexico, as well as an even larger group who are not under contract but come in as individuals, families, or clans from the Rio Grande Valley in Texas. The many problems relating to their housing, education, and medical care have prompted the suggestion that periodically the various state and social agencies immediately concerned meet with the State Medical Society to share experiences and see what methods can be taken to provide better care for these people while they are within the borders of the state and rendering an important economic service.

This past year such a conference was sponsored by the Committee on Industrial Health, and its success suggests the desirability of conducting similar meetings on a more systematic basis. The following agencies were represented: the Industrial Commission, the State and Federal Employment Service, the Division of Public Assistance, the Division of Children and Youth, the Governor's Committee on Human Rights, Wisconsin Hospitals, Wisconsin Canners Association and several county medical societies.

As an outgrowth of this meeting a study was conducted to ascertain how authorization for medical care of migrant workers should be secured in each county, and this information was transmitted to all county secretaries in composite form.

The many medical problems associated with the migrant worker suggest that in those areas most affected by the problem a special committee be set up with representatives of hospitals, relief departments, state employment offices, and other state agencies with local branches, so that problems can be handled with dispatch as they arise.

3. *Open Panel Program, Workmen's Compensation:* During the past year more than 50,000 panels for 1952–53 were distributed to employers covered by Workmen's Compensation, and two meetings of the Conference Committee have been held to settle disputes over alleged overcharges and to improve the matter of reporting on the simplified forms, which have lessened the work of the physician.

Contacts have been made with all self-insured employers, to extend to them the services of the Conference Committee and the acceptance of the Open Panel program. Great progress has been made in this respect, and the continued acceptance of the Wisconsin program which assures the free choice of physician on the part of the injured worker is most gratifying to those who developed the program some 16 years ago. The constantly decreasing number of cases where physicians fail to supply reports to the insurance carrier and the Industrial Commission is further evidence that the participation of more than 85 per cent of all members of the State Medical Society is highly successful and most satisfying to the employee who can secure his medical service from his family physician or a specialist of his choice, and not by way of restricted direction on the part of the employer.

Recommendations

(1) That all physicians lend support to the Industrial Health program through the active participation in clinics held in their areas, and that in local situations the physicians give attention to the possibility of rendering part-time supervision of health programs in smaller plants.

(2) That county medical societies in areas where there is a heavy concentration of migrant workers take the initiative in setting up county committees to meet the many problems (medical as well as those related to housing, education, and social adjustment) before they become acute.

(3) That all participants in the Open Panel program exercise special efforts to keep current with reports so that the principle of free choice of physician will receive continued support of the Industrial Commission, the insurance carriers, and the employers.

(4) That the Council on Medical Service develop an annual state conference in the field of medical-press relations, continue the area medical-press conferences into areas not already served, and to encourage local medical-press conferences wherever possible.

(5) That the Council on Medical Service develop a guide book on medical-press relations to be distributed to physicians, hospitals, newsmen, medical schools and schools of journalism.

(6) That the Council on Medical Service take steps to encourage all county medical societies to send at least one physician representative to the nearest sectional meeting of the third annual Rural Health Conference and that every effort be made to increase physician participation in the rural health conferences.

The reference committee was impressed with the comprehensive report of the Council on Medical Service. Its scope was indicated by the large number of subjects considered in its report. The reference committee heartily endorsed the six recommendations of the Council.

On motion of Doctor Kasten, seconded by Dr. D. N. Goldstein, Kenosha, carried, this section of the report was accepted.

Dues for 1953

The reference committee stated that two things must be obvious to the entire membership: the first is the substantial expansion in the Society's activities and services to the membership, a number of which are new within the past two years. The other is that the Society, in common with everyone else, feels the impact of inflation.

It was the judgment of this reference committee that if the House desired to continue the present program of the Society unimpaired, dues could not be reduced at the present time. It was equally the judgment of this reference committee that with the increasing demands on physician incomes, dues should not be increased. It was therefore the recommendation that the dues be continued at $60 for the year 1953.

On motion of Doctor Kasten, seconded by Dr. T. W. Tormey, Jr., Madison, carried, this section of the report was accepted.

On motion of Doctor Kasten, seconded by Dr. J. W. Fons, Milwaukee, carried, the report was adopted as a whole.

ADJOURNMENT

The second session of the House adjourned at 7:45 p.m.

THIRD SESSION

Tuesday, October 7, 1952

The third session of the House of Delegates convened at 9:20 a.m., Dr. W. D. Stovall, Vice–Speaker, presiding.

REPORT OF THE COMMITTEE ON CREDENTIALS

The Committee on Credentials verified the registration of 48 delegates and 14 alternate delegates entitled to vote at this session of the House of Delegates. In addition, five councilors and three past-presidents registered their attendance.

It was moved by Doctor Aylward, seconded by Dr. E. C. Cary, Reedsville, carried, that the attendance roll of delegates and alternates totaling 62 be accepted as the official roll of this session of the House, to stand for the entire session.

REPORT OF COMMITTEE ON NOMINATIONS

The names of the following nominees were presented for official positions in the State Medical Society:

For President-elect: Dr. H. Kent Tenney, Madison

For Speaker of the House: Dr. George Forkin, Menasha

For Vice–Speaker of the House: Dr. J. W. Fons, Milwaukee

For Delegates to the American Medical Association: Drs. S. E. Gavin, Fond du Lac, and D. H. Witte, Milwaukee

For Alternate Delegates to the American Medical Association: Drs. L. O. Simenstad, Osceola, and J. C. Griffith, Milwaukee

Milwaukee was the choice for the next Annual Meeting of the Society.

On motion of Dr. G. W. Carlson, Appleton, seconded by Dr. E. J. Schneller, Racine, carried, Doctor Tenney was unanimously elected to the office of president-elect. Vice–Speaker Stovall appointed a special committee, composed of Dr. E. C. Cary, Reedsville; Dr. T. A. Leonard, Madison; and Dr. J. W. Prentice, Ashland, to escort the president-elect to the platform.

On motion of Dr. E. C. Cary, Reedsville, severally seconded and carried, Doctor Forkin was unanimously elected as Speaker of the House.

On motion of Dr. L. O. Simenstad, Osceola, seconded by Dr. H. H. Christofferson, Colby, carried, Doctor Fons was unanimously elected Vice–Speaker of the House. He was granted the privilege of the floor, and moved that the House extend to Roy Ragatz, assistant secretary, its grateful appreciation for the entertainment provided at the Smoker the preceding evening. The motion was severally seconded and carried.

On motion of Dr. J. W. Fons, Milwaukee, seconded by Dr. D. N. Goldstein, Kenosha, carried, Doctor Gavin was unanimously re-elected delegate to the American Medical Association.

On motion of Dr. E. C. Cary, Reedsville, seconded by Dr. T. J. Aylward, Milwaukee, carried, Doctor Witte was unanimously re-elected delegate to the American Medical Association

On motion of Dr. W. C. Henske, Chippewa Falls, seconded by Dr. Woodruff Smith, Ladysmith, carried, Doctor Simenstad was unanimously re-elected alternate delegate to the American Medical Association.

On motion of Dr. P. B. Mason, Sheboygan, severally seconded, carried, Doctor Griffith was unanimously re-elected alternate delegate to the American Medical Association.

On motion of Dr. F. E. Drew, Milwaukee, seconded by Dr. L. O. Simenstad, Osceola, carried, Milwaukee was selected as the place for the 1953 meeting.

ELECTION OF COUNCILORS

The House then proceeded to the election of councilors with the following results:

In the Third District, on motion of Dr. M. W. Stuessy, Brodhead, severally seconded, and carried, Dr. N. A. Hill of Madison was elected.

In the Fourth District, on motion of Dr. T. F. Farrell, Prairie du Chien, seconded by Dr. P. B. Mason, Sheboygan, carried, Dr. E. M. Dessloch, Prairie du Chien, was re-elected.

In the Fifth District, on motion of Dr. E. C. Cary, Reedsville, seconded by Dr. E. W. Humke, Chilton, carried, Dr. A. H. Heidner, West Bend, was re-elected.

In the Sixth District, on motion of Dr. G. W. Carlson, Appleton, seconded by Dr. G. R. Anderson, Neenah, carried, Dr. A. J. McCarey, Green Bay, was re-elected.

In the Twelfth District, on motion of Dr. J. W. Fons, Milwaukee, seconded by Dr. T. J. Aylward, carried, Dr. William Casper, Milwaukee, was elected.

ACCEPTANCE OF THE PRESIDENT-ELECT

Dr. H. Kent Tenney was escorted to the platform by the special committee appointed by the Vice–Speaker. In his speech of acceptance, Doctor Tenney made the following remarks:

I find myself in rather a paradoxical situation at this moment. At the caucus of the Third District delegates I asked to be relieved of the position of councilor, on the ground that I did not like the responsibilities and the time I had to spend at the work. I must admit I was a little surprised at the alacrity with which the delegates accepted my suggestion. But now look! I am infinitely worse off, and so are you. (Laughter)

Last night, at the last session of the House, you accepted several reports that came in from your reference committees. According to parliamentary procedure, acceptance of a report carries with it responsibility by the House. Maybe you did not know that, but that is in Robert's Rules of Order. Therefore, the House has accepted responsibility in two matters that I would like to mention briefly.

One is in relation to the study of maternal deaths. I hope that when you go back to your constituent societies you will emphasize that this is in no manner an inquisition or an inquiry into any individual's method of treatment and conduct of his cases. What that committee is after is the facts as to what happened, not why any treatment was given—just what happened. In that way it may be possible, after collecting all the facts, to further reduce maternal mortality in Wisconsin.

The experience of childbirth in Wisconsin is a pretty safe thing today, but it is believed by the committee that by a thorough study it may be reduced still further, to that irreducible minimum. Therefore, I hope you will tell all of your constituents that when this committee comes around to them, they will not inquire into how the doctors practice medicine—they simply want their help in making safer yet the experience of childbirth.

The other matter is in relation to the report on prepaid medical care. I must admit that I have some apprehension over the slower sale of our plan. Perhaps that is of no significance, and probably it is not, particularly during this transition period.

However, remember that in accepting the Commission's report you accepted the responsibility of staying with it. I think it has been said that no army that is worth anything is free from griping. Griping there will be, but it does not mean that we have a bad army.

Also, it is true that no army is worth anything if it will not rally to the ideals for which it is fighting. We are fighting for the preservation of the prepaid plan of medical insurance as one of our answers to the threat of socialized medicine. So, during what may be a trying time please rally this army to the support of that ideal.

Gentlemen, thank you very, very much for the honor you have bestowed on me. (Applause)

REMARKS BY DR. G. E. FORKIN, NEW SPEAKER

Dr. E. C. Cary of Reedsville asked permission of the House for Dr. G. E. Forkin, newly elected Speaker, to address the group. Doctor Forkin made the following statement:

I hope to know you a lot better in the course of the next year. I have been elected to this job in quite an unusual manner. We look over this field and see the number of men who have fought and bled for the State Medical Society—men who have put in hours and hours of arduous work, and we see those gentlemen bypassed in favor of a man who is merely an infant in this organization's activities, although he has served for years as a member of this Society. I have never been a member of this House of Delegates until this year. I feel that I have been suddenly dropped right in the center of a maelstrom that is going to floor me. I have a lot to learn.

My past experience has taught me to lean upon and to take advice from men who have had more experience than I, and I hope I am going to have the benefit of the many years of wisdom and experience that you men have had.

All I can say is that what I lack in experience I certainly will make up in energy and willingness to work. We all feel that we are engaged in the greatest profession of all, with the highest ideals, and I certainly assure you gentlemen that I shall do all I can to further the ideals of this wonderful profession of medicine, as well as to support the organization we have seen function and grow for so many years, with the eminence it has in the country today.

Thank you. (Applause)

ADJOURNMENT SINE DIE

On motion of Dr. F. E. Drew, Milwaukee, severally seconded, carried, the House of Delegates adjourned, sine die at 10:00 a.m.

UNIVERSITY OF WISCONSIN SPONSORS POSTGRADUATE COURSE

The University of Wisconsin Medical School will sponsor a postgraduate course on "Neurology and Psychiatry in General Practice," to be held January 6, 7, and 8, at the University. The course will feature practical presentations which the general practitioner will find of use in his daily work.

Enrollment is limited to the first 40 applicants and advance registration is necessary.

PROGRAM

Tuesday, January 6—(Neurology)

A. M.

8:00 Registration
8:30 Welcome—Dr. R. C. Parkin
Announcements—Dr. W. J. Bleckwenn
9:00 Demonstration of a Practical Neurological Examination—Dr. E. P. Roemer
9:30 Neurological Clinic—Dr. H. A. Peters
10:30 Diagnostic Laboratory Procedures:
a) Cerebrospinal Fluid Examination—Doctor Bleckwenn
b) Pneumoencephalography—Doctor Bleckwenn
c) Myelography—Dr. H. H. Reese
d) Arteriography—Doctor Reese
11:30 Roentgenology of Skull and Spine—Dr. L. W. Paul

P. M.

12:15 Informal Luncheon (Included in Fee)—Cafeteria
1:30 Neuroanatomical Orientation — Dr. F. D. Geist
2:30 Initial Management of Acute Brain Injury —Dr. T. C. Erickson
3:30 Cerebral Vascular Accidents — Doctor Bleckwenn
4:30 Electroencephalography—Dr. W. E. Gilson

Wednesday, January 7

A. M.

8:00 Epilepsies—Dr. M. G. Masten
9:00 Demyelinizing Diseases—Doctors Reese and Roemer
10:00 Neuridites and Neuropathies — Doctor Masten
11:00 Newer Drugs in Neurology—Doctors Reese and Peters

P. M.

12:15 Round Table Luncheon (Inc. in fee)

Wednesday, January 7—(Psychiatry)

P. M.

1:30 Dynamic Psychiatry—its significance—Dr. N. A. Cameron
2:30 The Social Problem and History — Mrs. E. C. Wright
5:00 Psychological Evaluation—Dr. W. F. Fey
Behavior Problems (case presentation)—Dr. L. A. Osborn
6:00 Social Hour and Dinner—Hoffman House (Included in fee)
8:00 The Problem of the State Dept. of Public Welfare—Mr. J. W. Tramburg
8:30 to 10:00 Entertainment

Thursday, January 8

A. M.

8:00 Child Psychiatry (Child Guidance Clinics) —Dr. E. S. Cameron
9:00 Anxiety—Dr. Robert Roessler
10:00 Conversion Hysteria—Dr. E. R. Hodgson
11:00 Depressive Reactions — Dr. A. C. Washburne

P. M.

12:15 Round Table Luncheon (Inc. in fee)
1:30 Shock Therapies (with demonstrations)—Dr. B. H. Glover
2:30 The Involutional Period—Dr. Fritz Kant
3:30 Psychosomatic Problems—Dr. T. H. Lorenz
4:30 Alcoholism and its Management — Doctor Kant

COMMITTEE *Concentrates*

MATERNAL MORTALITY
OCTOBER 10

MDs present: (Study Committee): T. A. Leonard, chairman, J. W. Harris, F. J. Hofmeister, Alice Watts, R. J. Sanderson, E. D. Wilkinson. . . . (Interviewers): Carl Neidhold, W. O. Paulson, J. F. Egan, H. M. Carter, W. V. Luetke, G. C. Hank, R. E. McDonald, M. A. Krembs, G. S. Kilkenny, F. N. Pansch, Florence Duckering

Primary purpose of this meeting was to have the Study Committee and the interviewers meet to outline the basic plans for the maternal mortality study, which will be started in 1953. General procedures reviewed, and clarification as to methods which will be employed to secure the information from the attending physician and the hospital which will permit the Study Committee to evaluate the individual case and offer advice to the physician and others who were in close contact with the case.

Doctor Leonard, as chairman of the Study Committee, will prepare various interpretive communications which will be distributed to hospital staffs, county medical societies, and others immediately concerned with the program.

COMMITTEE ON PUBLIC POLICY
OCTOBER 18–19

MDs present: J. M. Sullivan, chairman, S. E. Gavin, J. A. Schroder, J. A. Enright, J. C. Griffith, H. Kent Tenney

At its second meeting the committee, in its comprehensive study of the Basic Science Law and the entire Medical Practice Act, considered revisions to make them more modern and effective . . . reviewed a revision of the criminal code as presented by the Legislative Council of Wisconsin, with Assistant Attorney General Platz and representatives of the U of W Law School . . . considered legislation relative to coroners, chiropodists, and limited licensees . . . multiple county health departments . . . medical testimony of out-of-state doctors . . . privileged communication and the nurse . . . recommendation of the Committee on TB and Chest Diseases re clarification of the "free care" law as to diseases treated.

CLAIMS COMMITTEE OF COMMISSION ON PREPAID PLANS
OCTOBER 29

MDs present: C. G. Reznichek, chairman, J. T. Sprague, N. A. Hill, R. C. Parkin, H. Kent Tenney, L. V. Littig, L. W. Paul, F. F. Golden

Considered several policy matters for recommendation to the Commission . . . radioactive iodine treatment of toxic goiter classified as neither medical nor surgical, but as radiation therapy; recommend contract interpretation that medical care benefits pick up automatically before usual preoperative and after usual postoperative care; discussed manner of benefit payment for interpretation of x-ray with three radiologists present and recommended that any professional services rendered in connection with x-ray be recognized as radiology services up to maximum benefits in the fee schedule; recommended that accidental injuries be treated as surgical cases even though treated medically . . . decided a number of problem cases.

COMMITTEE ON PUBLIC POLICY
NOVEMBER 9

MDs present: J. M. Sullivan, chairman, S. E. Gavin, J. A. Schroder, J. A. Enright, J. K. Curtis, J. C. Griffith, H. Kent Tenney

At its third meeting the committee reconsidered revisions to the Medical Practice Act, reviewed at October meeting, with Drs. J. W. Prentice, E. W. Miller, A. G. Koehler, H. H. Christofferson and E. C. Murphy . . . had specific discussions re introduction of amendment for "temporary educational certificate" permitting an individual whose school of graduation is not approved for licensure to engage in educational training in state as an intern or resident . . . health personnel in state service . . . epilepsy laws . . . proposed study of high rate of fatal and near-fatal automobile accidents. Many other matters were reviewed and the committee anticipates active duties during early part of 1953 when legislation is first presented for consideration, and will follow legislative creed of the profession in Wisconsin, based on philosophy that that which is in the interest of public health must necessarily be in the interest of the medical profession.

COUNCIL ON SCIENTIFIC WORK
NOVEMBER 13

MDs present: T. O. Nuzum, chairman, J. W. Gale, S. A. Morton, P. A. Midelfart, M. G. Rice, R. S. Baldwin, W. S. Middleton, J. S. Hirschboeck.

Primarily an organizational meeting, and a discussion of what type of scientific program should be prepared for the 1953 Annual Meeting. Assigned duties of council members for 1953: T. O. Nuzum, chairman; J. W. Gale, general program chairman for 1953 Annual Meeting; P. A. Midelfart, director of postgraduate teaching programs for 1954; S. A. Morton, chairman, scientific exhibits for 1953 Annual Meeting; M. G. Rice, chairman, special demonstrations, 1953 Annual Meeting.

Council reviewed 1952 meeting and various reasons why it was not as successful, in terms of physician participation, as previous meetings. Decision to feature specialty meetings in mornings and general assembly in afternoon. Recommends to Council of the SMS that dates be shifted so that scientific programs on Tuesday, Wednesday and Thursday, with golf tournament and other related activities on Monday. Also recommends ultimate shift in meeting dates to late April and early May as early as possible. This may not materialize until 1955. Council reviewed scientific section of Journal, and suggested several changes which would be helpful to those members who keep the scientific material together in bound form.

EXECUTIVE COMMITTEE OF COMMISSION ON PREPAID PLANS
NOVEMBER 13

MDs present: E. M. Dessloch, chairman, Robert Krohn, H. E. Kasten

Recommended a revised PSR deleting some 10 questions from the present form . . . decided to invite Executive Committe of Associated Hospital Service to December Commission meeting . . . approved a procedure for securing refunds from physicians of erroneous WPS payments . . . other routine matters.

COMMITTEE ON CANCER
NOVEMBER 15

MDs present: A. R. Curreri, chairman, W. S. Bump, A. C. Taylor, R. P. Welbourne, J. W. Conklin, J. E. Conley

Most of committee's activity as the Medical and Scientific Committee of the Wisconsin Division, American Cancer Society was discussed. Consideration given to desirability of sponsoring the special training of technicians for cytologic service in various pathologic laboratories in the state. Agreed to consult with Wisconsin Society of Pathologists to secure their reaction to the proposed program, and if favorable, to set up a joint committee for further planning and determination under what conditions such services would be sponsored and paid for by funds of the Wisconsin Division of the American Cancer Society. . . . Considered complaint of some volunteer workers that in some areas the doctors fail to support the cancer program, either financially or by way of public endorsement. Committee to send special communications to county medical societies appealing for their support, individually and as a county society. . . . Agreed to support general postgraduate program of SMS for 1953 by contribution of $500, and recommended the planning of a three-day cancer clinic circuit in the late Spring, with the dates and locations selected so as not to conflict with the general postgraduate meetings.

GRIEVANCE COMMITTEE
NOVEMBER 20

MDs present: R. E. Fitzgerald, chairman, C. E. Zellmer, F. A. Nause, E. W. Mason, H. Kent Tenney

RELATED ACTIVITIES

Since last report of committee concentrates many members of the staff have been busy with related activities . . . . successful rural health conferences held in Green Bay, Madison, Wausau and Eau Claire in November. Outstanding contributions to programs made by Drs. R. L. MacCornack, W. D. Stovall, H. K. Tenney, III, R. M. Lotz, Rex Graber, E. P. Ludwig, G. M. Shinners, C. E. Hopkins, M. W. Stuessy, E. M. Paine, and G. B. Merline. Meetings emphasized value of small "grass roots" conferences. . . . Successful state conference on "Physicians and Schools" held in Madison on Oct. 17–18, with SMS as major sponsor. More than 300 leaders in public health, the medical profession, nurses, PTA officers, and educators in attendance. Many physicians on the program, and total of 44 physician members registered for the conference. Net result: good PR for the SMS and for the medical profession in general. Requests from many sources that similar conferences be planned, but holding up until 1954, so as to avoid "wringing the towel dry" through too frequent conferences. . . . SMS had pleasure of helping local MDs in conducting the very successful program of the GPs in Madison on Nov. 11–12. Meetings on both days well attended, and a lot of enthusiasm evident among members. More than half of state membership in Academy registered, and among other items of business they scooped up over $1,500 for support of the new Academy building in Kansas City. J. W. Fons, Milwaukee, goes in as president, and C. G. Reznichek, Madison, named president-elect.

. . . . THE PRESIDENT'S PAGE . . . .

SPEAKING this month at the Denver meeting of the American Medical Association, the president, Dr. Louis H. Bauer, stated that, "Too often the public thinks of the American Medical Association only as a group which is in the forefront in the fight against socialism. In reality, 90 per cent of all American Medical Association activities are in the scientific field."

This is as it should be if we are to continue the rate of scientific advancement that has been set for us in this century. I believe that we, here in Wisconsin, are keeping pace.

Progress in medicine depends on scientific research, clinical investigation, and postgraduate study.

Research revolves for the most part around our universities, hospitals, and teaching centers where the means of research are more readily available.

Clinical investigation is an individual venture that is beneficial to the clinician personally and to his colleagues. The thorough study of just one interesting case will help, but better still is the thorough study of several similar cases, writing them up and if they are not published they will be very welcome at your own staff meeting.

The need and value of postgraduate education is unquestioned but presents considerable difficulty after we are established in practice. Medical literature is voluminous, and it requires diligence to obtain medical facts. Hospital staff meetings, pathologic conferences, and county and state medical meetings deserve our participation. The one or two week postgraduate course available at our universities is perhaps the most valuable of all but requires absence from our practice and community for which we rightly feel a responsibility.

Cognizant of this your State Society through its Council on Scientific Work has established a series of teaching programs that will bring a concentrated postgraduate course right to your door.

From January through June these will be given, three each month. They will be one day courses and each series of three will be in the same section of the state so that if it is impossible for you to attend on any given day, the same course will be available the next day in an adjacent city. The teaching will be done by teams from the medical schools of the University of Wisconsin and Marquette University. These courses have been carefully planned and the teaching will be basic, bringing you the information you are looking for as to the accepted present day concepts in medicine, pediatrics, obstetrics, and surgery. The courses will be practical and will cover specific diseases, the best means of diagnosis, and their management. They will cover treatment, indications and contraindications for the newer drugs, and the actual dosages of each. They will warn of the pitfalls of which we must beware.

In another part of this Journal will be found the entire program. Study it now and see when it will be in your section of the state and remember that if you are unable to attend one day, the same course will be available on the two following days in nearby cities.

May I earnestly urge your participation.

J. C. Griffith M.D.

1953 CLINICS ANNOUNCED

TEACHING PROGRAMS COVER ENTIRE STATE FOR COMING YEAR

J. W. GALE, M.D.

The Council on Scientific Work, through J. W. Gale, M.D., chairman of the 1953 postgraduate teaching program, is pleased to announce a full six months of weekly circuits, covering the entire state and offering a wide array of teaching talent from Wisconsin and many out-of-state medical teaching centers.

The 1953 postgraduate teaching program is the most comprehensive ever undertaken by the State Medical Society, and represents an operating budget of more than $7,000. Of this nearly $3,000 will be provided by the State Board of Health, contributions of $500 each have been received from the Wisconsin Heart Association and the Wisconsin Division of the American Cancer Society, and the balance will be paid by registration fees and from the treasury of the State Medical Society out of funds specifically budgeted for that purpose.

All of these clinics have been certified by the Wiseonsin Aeademy of General Praetiee, and attendance will provide 5 hours of formal teaching credit for eontinued membership in the Academy.

Each program starts at 2:00 p.m., so that physicians can complete their hospital assignments in the morning, and with the exception of those meetings designated as Councilor District Meetings, the scientific program will extend into the early evening, following dinner. For the Councilor District Meetings the evening sessions will be non-scientific in character with officers of the Society and others prominent in medical economic circles as speakers.

All members who are interested in participating in these programs are urged to make reservations by use of the form printed on page 1305.

JANUARY

TUESDAY, JANUARY 13: Lake Delton (Dell View Hotel)

WEDNESDAY, JANUARY 14: Sparta (City Hall Auditorium and Sidney Hotel)

THURSDAY, JANUARY 15: Eau Claire (Eau Claire Hotel)
COUNCILOR DISTRICT MEETING

Robert C. Parkin, M.D., Madison, Moderator
(Program from 2:00–5:00 p.m.)

Office Gynecology: Ralph A. Reis, M.D., Professor of Obstretrics and Gynecology, Northwestern University Medical School, Chicago

Some Common Endocrine Problems in Infancy and Childhood: Irvine McQuarrie, M.D., Professor and Head of Department of Pediatrics, University of Minnesota Medical School, Minneapolis

Diagnosis and Treatment of Coronary Artery Disease: Francis F. Rosenbaum, M.D., Assistant Clinical Professor of Medicine, Marquette University School of Medicine, Milwaukee

The Problem of Serious and Fatal Reactions to Drugs: J. E. Steinhaus, M.D., Ph.D., Associate Professor of Pharmacology, University of Wisconsin Medical School, Madison

FEBRUARY

TUESDAY, FEBRUARY 10: Lancaster (Grantland Club Rooms, City Hall, and Wright Hotel)

WEDNESDAY, FEBRUARY 11: Janesville (Hotel Monterey)
COUNCILOR DISTRICT MEETING

THURSDAY, FEBRUARY 12: Fond du Lac (St. Agnes Hospital and Elks Club)

George E. Collentine, Jr., M.D., Milwaukee, Moderator
(Program from 2:00–5:00 p.m.)

The Management of Bleeding in Pregnancy: F. J. Hofmeister, M.D., Clinical Instructor in Obstetrics and Gynecology, Marquette University School of Medicine, Milwaukee

Surgical Emergencies: E. S. Brintnall, M.D., Assistant Professor of General Surgery, State University of Iowa College of Medicine, Iowa City

Insulin Therapy: F. B. Peck, M.D., Associate Professor of Medicine, Indiana University School of Medicine, and Director, Medical Division, Lilly Research Laboratories, Indianapolis

The Cerebral Palsied Child: R. R. Rembolt, M.D., Associate Professor of Pediatrics, and Director of Iowa Hospital School, State University of Iowa College of Medicine, Iowa City

MARCH

TUESDAY, MARCH 24: Beaver Dam (Elks Club)

WEDNESDAY, MARCH 25: Marshfield (Nurses Auditorium and Charles Hotel)

THURSDAY, MARCH 26: Neenah (Theda Clark Hospital and Valley Inn) COUNCILOR DISTRICT MEETING

Robert C. Parkin, M.D., Madison, Moderator

(Program from 2:00–5:00 p.m.)

Recent Advances in the Prevention and Treatment of Rheumatic Fever: Richard V. Ebert, M.D., Professor of Medicine, University of Minnesota Medical School, Minneapolis

Practical Aspects of Congenital Heart Disease in Children: James Du Shane, M.D., Assistant Professor of Pediatrics, Mayo Foundation Graduate School, University of Minnesota Medical School

Diagnosis and Management of Bleeding in Early Pregnancy: M. Edward Davis, M.D., Joseph Boliver DeLee Professor of Obstetrics and Gynecology, Lying-in Hospital, University of Chicago

Geriatric Surgery: Erwin R. Schmidt, M.D., Professor and Head of Department of Surgery, University of Wisconsin Medical School, Madison

APRIL

TUESDAY, APRIL 14: West Bend (Thoma's Resort, Little Cedar Lake)

WEDNESDAY, APRIL 15: Shawano (Bilmay Hotel)

THURSDAY, APRIL 16: Stevens Point (Whiting Hotel) COUNCILOR DISTRICT MEETING

George E. Collentine, Jr., M.D., Milwaukee, Moderator

(Program from 2:00–5:00 p.m.)

A Clinical Approach to Common Infections: Burton A. Waisbren, M.D., Clinical Instructor of Medicine, Marquette University School of Medicine, Milwaukee

Office Gynecology: Herbert E. Schmitz, M.D., Professor and Chairman, Department of Obstetrics and Gynecology, Stritch School of Medicine of Loyola University, Chicago

Traumatic Surgery as It Concerns the General Practitioner: John T. Reynolds, M.D., Assistant Professor of Medicine, University of Illinois College of Medicine, Chicago

Treatment of Arrhythmias: Richard Langendorf, M.D., Associate Attending Physician and Research Associate, Cardiovascular Department, Michael Reese Hospital, Chicago

MAY

WEDNESDAY, MAY 13: Delavan (Lake Lawn Resort)

THURSDAY, MAY 14: Sheboygan (Pine Hills Country Club)

FRIDAY, MAY 15: Green Bay (Elks Club)

Joseph W. Gale, M.D., Madison, Moderator

(Program from 2:00–5:00 p.m.)

Metabolic Problems in General Practice: E. S. Gordon, M.D., Associate Professor of Medicine, University of Wisconsin Medical School, Madison

Recent Advances in Obstetric Practice: John Parks, M.D., Professor and Head of Department of Obstetrics and Gynecology, George Washington University, Washington, D. C.

The Problem of Chronic Cystic Mastitis with Special Reference to Its Relation to Carcinoma: Robert Elman, M.D., Professor of Clinical Surgery, Washington University School of Medicine, St. Louis

The Convulsive Disorders in Childhood: M. G. Peterman, M.D., Head of Department of Pediatrics, Milwaukee County Hospital, Milwaukee

JUNE

WEDNESDAY, JUNE 24: Hayward (Radio Joe's Inn)

THURSDAY, JUNE 25: Minocqua (Minocqua Country Club)

PHYSICIANS' WIVES ARE INVITED TO ATTEND THESE CLINICS. SPECIAL ENTERTAINMENT WILL BE PROVIDED.

E. H. Jorris, M.D., Madison, Moderator

(Program from 2:00–5:00 p.m.)

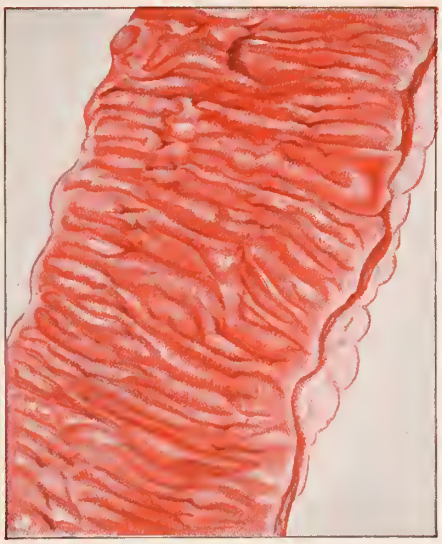
Some Newer Concepts Concerning the Prevention and Treatment of the Late Toxemias in Preqnancy: John W. Harris, M.D., Professor and Chairman of the Department of Obstetrics and Gynecology, University of Wisconsin Medical School, Madison

Recent Advances in Pediatrics of Importance in General Practice: Charles May, M.D., Professor and Head of the Department of Pediatrics, State University of Iowa College of Medicine, Iowa City

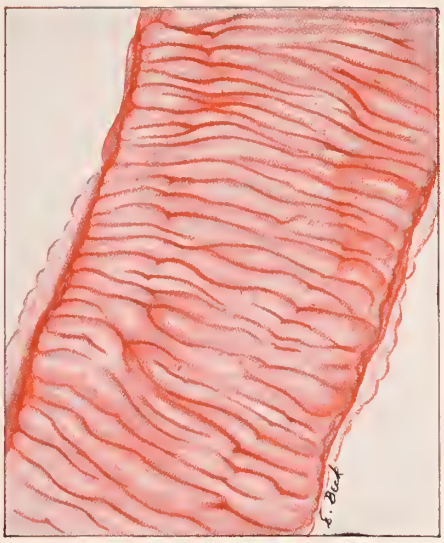
The Clinical Significance of Vascular Changes in the Skin: William Bean, M.D., Professor and Chairman of the Department of Internal Medicine, State University of Iowa College of Medicine, Iowa City

For Reservation Blank See Page 1305—Advance Reservation Desired

Promotes Normal Peristalsis— Without Injury to Mucosa



Irritated, injected mucosa such as is produced by roughage.



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* Block, L. H.: Management of Constipation with a Refined Psyllium Mucilloid Combined with Dextrose, Am. J. Digest. Dis. *14*:64 (Feb.) 1947.

SEARLE RESEARCH IN THE SERVICE OF MEDICINE

Facts about

Blue Shield of Wisconsin

an agency of the State Medical Society of Wisconsin

Prepared by the Commission on Prepaid Plans of the State Medical Society of Wisconsin, E. M. Dessloch, Prairie du Chien, Chairman.

Blue Cross Rate Increase May Bring Questions to Physicians

A general rate increase for all Blue Cross subscribers will become effective on January 1, 1953. Many physicians will be questioned by persons who mistake the increase as applying also to Blue Shield. *All physicians should clearly distinguish between the forthcoming Blue Cross rate increase and the recent Wisconsin Physicians Service (Blue Shield) expansion of benefits.*

The need for the Blue Cross rate increase was caused by two factors: the continued increase in the incidence of hospitalization and higher hospital costs. However, Blue Cross announced substantial benefit increases for its standard conversion members (persons who retained coverage after leaving groups) —representing about 20 per cent of the total Blue Cross enrollment. Other benefits, of a minor nature, were given to group members.

The table above compares the old and new Blue Cross rates for single and family subscribers under group and non-group contracts.

The January 1 increase applies only to Blue Cross contracts for hospitalization benefits. Wisconsin Physicians Service rates for the new surgical-medical coverage are *not* part of this increase.

Since June 1, 1952, Wisconsin Physicians Service subscribers have had the opportunity to convert their old contracts to the new "A" and "B" contracts. These conversions are being made monthly on the anniversary dates of the contracts.

The higher cost of the new "A" and "B" Blue Shield contracts over the old program is the reflection of greatly increased benefits and coverage. Under the new programs, payment for in-hospital medical care starts the first day and commands substantially higher benefits than the old contract. In addition, the new contracts offer increased surgical benefits, higher full payment levels, and expanded anesthesia and x-ray benefits.

The tabulation at the left shows the rate schedule for the new "A" and "B" Wisconsin Physicians Service group and non-group contracts. The new plan provides graduated rates for groups of varying sizes—larger groups receiving lower rates. Under the old WPS program (see lower portion of table) the monthly rate for all groups was the same.

OLD AND NEW BLUE CROSS RATES

Type Contract	Monthly rates			
	Single		Family	
	Old	New	Old	New
Group				
Comprehensive	$1.40	$1.80	$3.80	$4.80
Standard	1.10	1.40	2.90	3.60
Non-Group	1.20	1.50	2.50	3.00

WPS RATES FOR NEW PROGRAM

Type of Contract	Schedule	Monthly Rates	
		Single	Family
Group			
0–25 employees			
*5 element	A	$1.45	$5.15
4 element	A	1.17	4.32
5 element	B	1.10	3.75
4 element	B	.90	3.15
25–199 employees			
5 element	A	1.35	4.80
4 element	A	1.10	4.02
5 element	B	1.00	3.50
4 element	B	.83	2.40
Over 200 employees			
5 element	A	1.30	4.50
4 element	A	1.07	3.77
5 element	B	.95	2.80
4 element	B	.80	2.40
Non-Group			
5 element	A	1.85	4.70
4 element	A	1.40	3.70
5 element	B	1.45	3.50
4 element	B	1.10	2.70

WPS RATES FOR OLD PROGRAM

	Single	Family
Group (any size)	$ .90	$2.50
Non-Group	1.20	3.00

*5 element coverage is surgical-medical. 4 element, excludes medical coverage.

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SOCIETY PROCEEDINGS

Brown–Kewaunee–Door

L. J. VAN HECKE

Meeting at the Elks Club in Green Bay, the members of the Brown-Kewaunee–Door County Medical Society had as their special guest *Dr. L. J. Van Hecke* of Milwaukee. Doctor Van Hecke's talk was entitled "Coronary Arteriosclerosis." Another part of the scientific program was the showing of a film on "Blood Banking" by two representatives of the Karrer Company.

Crawford

The regular meeting of the Crawford County Medical Society was held on October 22 at the Old San Hotel in Prairie du Chien. This was a business meeting which was devoted to a report by the Crawford County delegate and alternate to the State Medical Society.

Dodge

The annual election of officers was held by the Dodge County Medical Society on October 30 at the Waupun Memorial Hospital. *Dr. H. G. Bayley* will be the new president, *Dr. C. L. Qualls*, vice-president; and *Dr. R. E. Urbanek*, secretary. All of the officers are from Beaver Dam. *Dr. L. W. Schrank* of Waupun, alternate delegate, gave a report on the October meeting of the House of Delegates.

Douglas

Dr. Gerald McGill of Madison, state director of alcohol studies, was the guest speaker at the November 5 meeting of the Douglas County Medical Society. Speaking before the members of the Society at the Hotel Superior, he discussed the "Merits of Adult Guidance Centers."

Members of the Douglas County Board of Trustees and Advisory Committee were also guests. They led a discussion on the establishing of a medical advisory committee, consisting of members of the Society, to assist in the medical problems in the county and its institutions.

Fond du Lac

"The Sequelae of Coronary Heart Disease" was the subject of an address by Dr. George Rukstinat, Chicago, at the October 23 meeting of the Fond du Lac County Medical Society. Doctor Rukstinat, who is professor of pathology at the Stritch School of Medicine, Loyola University, met with the members for dinner at the Elks Club in Fond du Lac, prior to the scientific program.

During the business session the Society voted to support the Student Loan Fund, and also approved the appearance in Fond du Lac of the State Board of Health mobile x-ray unit. *Dr. H. J. Kief* of Fond du Lac, alternate delegate, presented an interesting summary of the activities of the House of Delegates at the last October meeting. He also reported on the recent School Health Conference which was held in Madison.

Kenosha

A business meeting was held by the Kenosha County Medical Society on November 6 at the Elks Club in Kenosha. The main item on the evening's agenda was a discussion of the Kenosha Physicians Service Bureau. Although it was felt that the bureau, which has been in operation for two years, had been very successful, some suggestions for improvement were made. The Society voted to raise its dues to include a membership in the bureau for every member of the Society. In this way it would be possible for any one to locate a physician at any time. In addition, the bureau provides a rotating list of doctors for emergency calls.

Outagamie

At the October 16 meeting of the Outagamie County Medical Society, the following officers were elected to serve during 1953:

President—*W. S. Giffin*
Vice–President—*W. A. Adrians*
Secretary–Treasurer—*F. J. Rankin*
Delegate—*G. W. Carlson*
Alternate Delegate—*H. T. Gross*

All of the officers are from Appleton.

Pierce–St. Croix

The Hotel Dibbo at Hudson was the site of the meeting on October 21 of the Pierce–St. Croix County Medical Society. Mr. William DeParcq, Minneapolis attorney, was the guest speaker. He chose "Medical Witness and Malpractice" as the subject of his talk.

Portage

Dr. Ovid O. Meyer, chairman of the department of medicine at the University of Wisconsin Medical School, was the guest speaker at the October 28 meeting of the Portage County Medical Society. Doctor Meyer discussed "Newer Drugs and Their Uses."

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Winnebago

At the dinner meeting on November 5 at the Hotel Menasha, the members of the Winnebago County Medical Society heard an address by *Dr. Charles R. Taborsky* of Madison. The doctor, who is a clinical professor of otolaryngology at the University of Wisconsin Medical School, chose "New Methods of Detecting Hearing Loss" as the subject of his talk.

American Academy of General Practice Wisconsin Chapter

The Wisconsin Academy of General Practice held its fourth annual scientific meeting in Madison, November 10–12. The Board of Directors and the House of Delegates meetings were held on the first day. *Dr. Jerome W. Fons* of Milwaukee will be the organization's president for 1953, and the House of Delegates elected the following officers to serve with him: *Drs. C. G. Reznichek*, Madison, president-elect; *R. F. Purtell*, Milwaukee, secretary–treasurer; *D. C. Ausman*, Milwaukee, speaker of the House of Delegates; and *G. L. Boyd*, Kaukauna, vice speaker. New members of the Board of Directors are *Drs. L. V. McNamara*, Milwaukee; *R. R. Richards*, Eau Claire; and *M. O. Boudry*, Waupaca.

The last two days of the meeting were devoted to scientific programs which were outlined on page 1015 of the October issue of the Journal.

News Items and Personals

Life Has Been Kind

By Merton Field

Life has been kind, Long years ago
It took me by the hand to lead me on
Through paths, both difficult and strange.
I wished to go on ways unmarked,
Where I would follow on and on, heedless and unmindful,
Just that I might have my way.
But life was kind.

My will was strong and I would carve my way,
Regarding not the danger signs—
But life was kind, it kept me and led me on.

Life has been kind as down the corridors of time
I travelled on toward distant goals I could not know:
Drifting, and yet not drifting, for life was ever kind—
It gave me poise, sense, perspective, and direction,
When against my better judgment I would tarry—
Stray from off the path and falter.
Life has ever held me steady, guided me upon my way,
For, it was kind, it held me by the hand and led me on.

"In looking back in my life as a physician among simple people and their evident trust in me as their physician, I find much pleasure. Sweet memories of Nellie as I held her little hand when Life's dark shadows deepened and she moved into the darkness. Little Nellie had no fear when I was near.

"Memories carry me back to the tragedies in the lives of these simple people who gave me their complete trust as they would to a Father Confessor, and of the homes when Death seemed stayed while the fear-stricken family awaited my coming.

"Life has been to me wonderful in its experiences and opportunities and I would that I might live it again. But, in living I would minister to its simple people. . . ."

These excerpts are from the closing chapter of an autobiography being prepared by *Dr. Merton Field*, Chippewa Falls. Doctor Field has twice served as president and secretary of the Chippewa County Medical Society. He was recently honored with membership in the "50 Year Club" of the State Medical Society.

Testimonial Dinner Given for Dr. H. P. Conway

Three hundred friends and patients of *Dr. H. P. Conway*, practicing physician at Spring Valley for 50 years, attended a testimonial dinner given in recognition of the doctor's long years of service. Following the dinner, which was held at the Spring Valley Auditorium, Mayor Ed Bjornson served as master of ceremonies for a program which included musical numbers and talks by some of the doctor's friends. At the end of the entertainment, Doctor Conway was presented a new watch.

Doctor Heidner Addresses West Bend Group

Dr. A. H. Heidner, immediate past president of the State Medical Society, addressed the November 20 meeting of the West Bend Town and Country Club. The doctor chose "Socialized Medicine" as the subject of his talk.

Burlington Has New Doctor

Dr. William B. Helme, a graduate of the Stritch School of Medicine of Loyola University, has opened an office in Burlington. The doctor recently completed his internship at Milwaukee County General Hospital, Wauwatosa. Prior to studying medicine, he had been an agent of the F.B.I., and was skipper of a P–T boat in the South Pacific during World War II.

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ESTABLISHED 1899

Announcing THE SIXTEENTH ANNUAL MEETING OF

THE NEW ORLEANS GRADUATE MEDICAL ASSEMBLY

Conference Headquarters—Municipal Auditorium—March 2–5, 1953

GUEST SPEAKERS

J. Lamar Callaway, M. D., Durham, N. C.
DERMATOLOGY

A. H. Aaron, M. D., Buffalo, N. Y.
GASTROENTEROLOGY

Herbert E. Schmitz, M. D., Chicago, Ill.
GYNECOLOGY

Carl V. Moore, M. D., St. Louis, Mo.
HEMATOLOGY

Rudolph H. Kampmeier, M. D., Nashville, Tenn.
INTERNAL MEDICINE

Henry A. Schroeder, M. D., St. Louis, Mo.
INTERNAL MEDICINE

Guy L. Odom, M. D., Durham, N. C.
NEUROSURGERY

Andrew A. Marchetti, M. D., Washington, D. C.
OBSTETRICS

Harold F. Falls, M. D., Ann Arbor, Mich.
OPHTHALMOLOGY

J. Vernon Luck, M. D., Los Angeles, Calif.
ORTHOPEDIC SURGERY

G. Edward Tremble, M. D., Montreal, Can.
OTOLARYNGOLOGY

Arthur P. Stout, M. D., New York, N. Y.
PATHOLOGY

Waldo E. Nelson, M. D., Philadelphia, Pa.
PEDIATRICS

Edward B. D. Neuhauser, M. D., Boston, Mass.
RADIOLOGY

George Crile, Jr., M. D., Cleveland, Ohio
SURGERY

Robert E. Gross, M. D., Boston, Mass.
SURGERY

Charles W. Mayo, M. D., Rochester, Minn.
SURGERY

Wyland F. Leadbetter, M. D., Boston, Mass.
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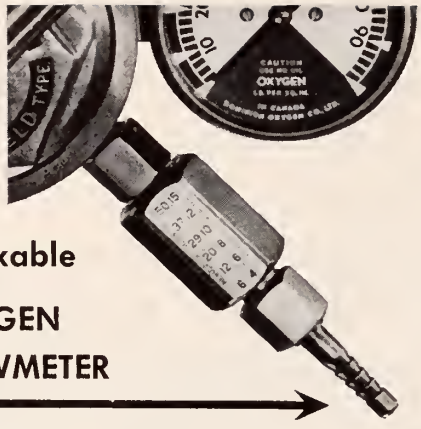

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Doctor Blose Opens Office in Durand

Dr. Irvin L. Blose, who recently completed his internship at Mercy Hospital, Chicago, has opened an office for general practice in Durand. The doctor received his bachelor of science degree from the John Carroll University, Cleveland, Ohio, and was associated for a time as a research assistant in the department of pathology of Cleveland City Hospital. He served as a line officer in the navy for four and a half years during World War II, prior to studying and receiving his degree in medicine from the Stritch School of Medicine of Loyola University.

Shortly after the doctor and his family had moved into their new home, a large number of the citizens of Durand surprised the family with an old fashioned house warming.

Doctor Starr to Begin Navy Service

Dr. Robert A. Starr, who has been associated with *Dr. R. S. Hirsch* in the practice of medicine at Viroqua, has been called up for service with the Navy. Doctor Starr plans to return to Viroqua to resume his practice after his Navy duty.

"Handicapped" Is Topic

Dr. H. J. Kief, Fond du Lac physician, addressed the first fall meeting of the Fond du Lac Association for the Handicapped. He told of new developments in the care of handicapped persons and discussed the progress of a reported polio vaccine.

Doctor Bland Begins Practice in Westby

Dr. Phillips T. Bland, who formerly practiced in Wittenberg, has opened an office in Westby. The doctor is a graduate of the University of Wisconsin Medical School and served his internship at the Philadelphia General Hospital. Upon completion of his studies, he established his first practice at Wittenberg and later was on active duty with the U. S. Navy.

Grandview Clinic Has New Staff Member

Dr. William A. Himmelsbach, who formerly was in private practice in Gallup, N.M., recently joined the staff of the Grandview Clinic, La Crosse, where he will specialize in the practice of pediatrics and internal medicine. A native of Northampton, Mass., the doctor received his M.D. degree at Georgetown University School of Medicine. He interned in New Orleans and completed his specialty training in hospitals in New Orleans, Lexington, Ky., and San Francisco.

Plymouth Physician Honored

Dr. Raymond H. Evers, Plymouth physician, was reelected president of the Wisconsin Sanatorium Superintendents Association at its annual meeting at Superior, September 12. Doctor Evers is superintendent and medical director of the Rocky Knoll Sanatorium. The superintendent's meeting was held

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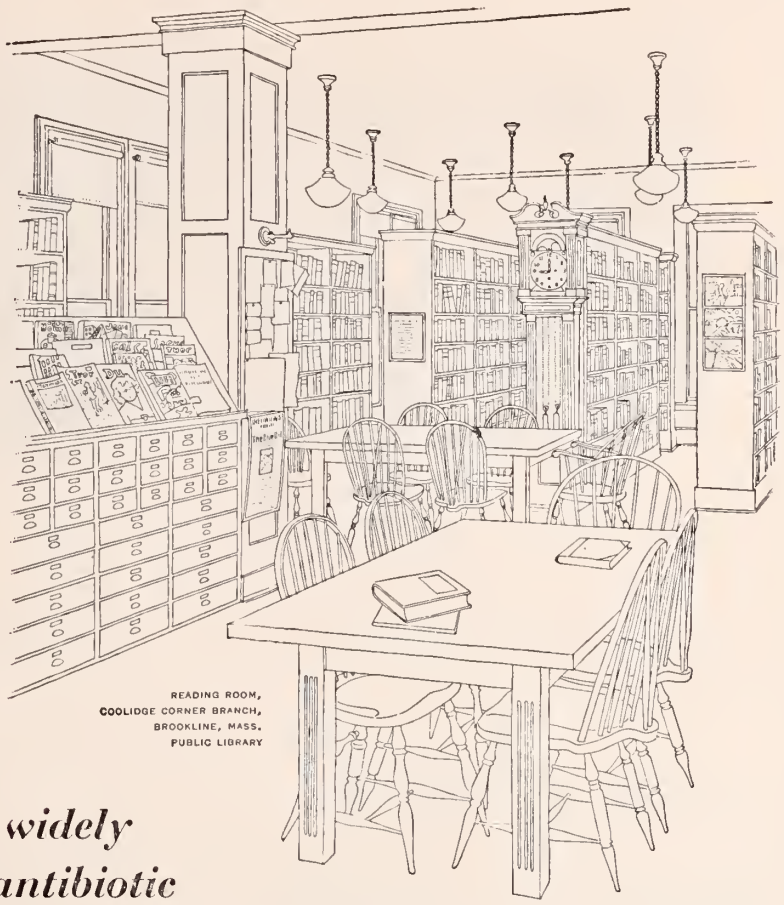

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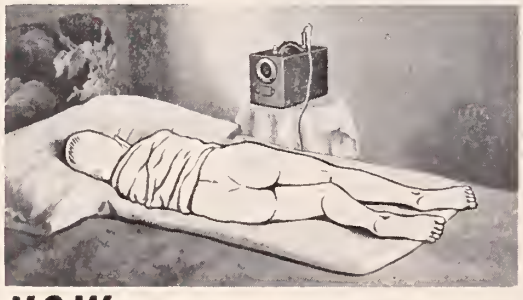

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jointly with the Wisconsin Sanatorium Trustees Association and was dedicated to better care for patients with the double handicap of TB and mental illness.

Doctor O'Neal Named Hospital Head

At the annual meeting of the medical staff of the Ripon Municipal Hospital, *Dr. Orvil O'Neal* was reelected to serve as president and chief of staff for the coming year. Other officers elected to serve with Doctor O'Neal are *Drs. A. C. Bachus*, vice president and Frank Wright, secretary.

Doctor Coyne Joins Fond du Lac Clinic

Dr. J. L. Coyne, Jr., who until recently was on active duty with the U. S. Air Force, has joined the staff of the Fond du Lac Clinic. Born in Portland, Maine, the doctor received his medical degree at the University of Pennsylvania School of Medicine. After finishing his internship at the Hurley Hospital, Flint, Mich., he joined the medical corps of the Air Force and served at Warren Air Force Base, Cheyenne, Wyoming, until July of this year.

THIRD AND TWELFTH DISTRICT NEWS

Doctor Handa Opens Office in Plain

Dr. Yoshio Handa, who recently completed his internship at St. Mary's Hospital, Madison, has established his practice in Plain. The doctor did his undergraduate work at the University of California and then studied at the Creighton University School of Medicine, Omaha, Neb., for his degree in medicine.

Doctor Bouman Honored

Dr. Harry D. Bouman, professor of physical medicine at the University of Wisconsin Medical School, has been elected editor of the American Journal of Physical Medicine. With the new editorship the magazine has changed its name from Occupational Therapy and Rehabilitation to the American Journal of Physical Medicine, in order to take in many of the newer fields which have developed within recent years.

U.W. Has New Staff Member

Dr. Alfred S. Evans, former chief of the hepatitis center and research laboratory, U. S. Army, Munich, Germany, has been appointed associate professor of preventive medicine and medical microbiology at the University of Wisconsin Medical School. Prior to his service with the Army, the doctor had been an assistant professor at Yale University School of Medicine.

Doctor Larkin to Practice in Madison

Dr. Charles B. Larkin, who recently received his release from the U. S. Air Force, will open an office

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Frank W. Mackoy, M. D. — John E. Leach, M. D.
J. Frampton Wyman, M. D. — Lloyd F. Jenk, M. D.
Hubert H. Blanchard, M. D. — James F. McDonald, Jr., M. D.
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for the general practice of medicine and surgery in Madison. A native of that city, the doctor is a graduate of the University of Wisconsin Medical School and interned at Madison General Hospital. During his duty with the Air Force he was stationed at Truax Field.

Green

Dr. Anthony R. Curreri, professor of surgery at the University of Wisconsin Medical School, was the guest speaker at the Green County Medical Society dinner meeting held on October 28 at the Monroe Country Club. Doctor Curreri recently returned from Korea where he made a survey of blood plasma and the possibility of expanders for the needed supply. His subject at the meeting was a discussion of the findings on the trip and various other research projects.

Rock

Officers were elected at the October 28 meeting of the Rock County Medical Society held at the Janesville Country Club. *Dr. R. S. Vivian,* Beloit, is the new president, and others chosen to serve with him are *Drs. Milton D. Davis,* Milton, vice-president; and *J. F. Pember,* Janesville, reelected secretary-treasurer.

For the scientific program, Captain Kenneth Vinnedge, executive officer of the Great Lakes Naval Hospital, was the guest speaker. His topic was "X-Ray Diagnosis in Acute Abdomen."

Doctor Anderson Honored by Pathologists

At a recent meeting of the College of American Pathologists, *Dr. W. A. D. Anderson* was elected vice-president for a term of three years. Doctor Anderson is professor and director of the department of pathology, Marquette University School of Medicine, and director of laboratories, St. Joseph's Hospital, Milwaukee.

Doctor Morgan Addresses W.A.T.A.

S. F. MORGAN

Dr. S. F. Morgan, chief of the cardiac clinic at Milwaukee Children's Hospital, was the guest speaker at the annual meeting of the Milwaukee Community Health Committee of the Wisconsin Anti-Tuberculosis Association, held at the YMCA on November 5. The title of his presentation was "Rheumatic Fever—Childhood's Greatest Enemy."

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Operating Roam in Hospital	10.00	20.00	30.00	40.00
Anesthetic in Haspital	10.00	20.00	30.00	40.00
X-Ray in Haspital	10.00	20.00	30.00	40.00
Medicines in Haspital	10.00	20.00	30.00	40.00
Ambulance ta ar fram Haspital	10.00	20.00	30.00	40.00
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MILWAUKEE

Milwaukeean Joins National Group

Dr. Joseph P. Wild, Milwaukee physician, was recently elected to membership in the American Academy of Plastic Surgery for Head and Neck. A native of South Milwaukee, the doctor is a graduate of the University of Louisville School of Medicine and served his internship at St. Luke's Hospital, Milwaukee.

Two Nurses' Groups Hear Doctor Kalb

"Treat or Retreat," a paper on overtreatment of allergic dermatoses, was presented by *Dr. C. H. Kalb* before the November 5 meeting of the Lake County Industrial Nurses' Association, held in East Chicago, Indiana.

Doctor Kalb also read a paper on the management of contact dermatitis in heavy industry at the November 13 meeting in Chicago of the first district of the Illinois State Nurses Association. The title of this paper was "Economics of Occupational Dermatitis."

Milwaukee

Dr. Gordon M. Meade, medical director of the Trudeau (N.Y.) Sanatorium addressed the November 13 meeting of the Medical Society of Milwaukee County, held at the Athletic Club. Doctor Meade, who formerly was an associate professor of medicine at the University of Rochester, discussed the treatment of tuberculosis with the new isonicotinic acid hydrazide drugs.

Pictured above, from left to right, are Drs. P. E. Oberbreckling, E. L. Bernhart (putting), and Maurice B. Byrnes, all of Milwaukee, competing in the annual Wisconsin Medical Golf Tournament.

Wisconsin Medical Golf Tournament

The Wisconsin Medical Golf Tournament was held at the Blue Mound Country Club in Milwaukee on October 8. One hundred and six doctors competed during the afternoon. The low gross trophy was awarded to *Dr. Harry P. Maxwell,* Milwaukee, who shot a 75. Low net was won by *Dr. J. H. Hogan* of

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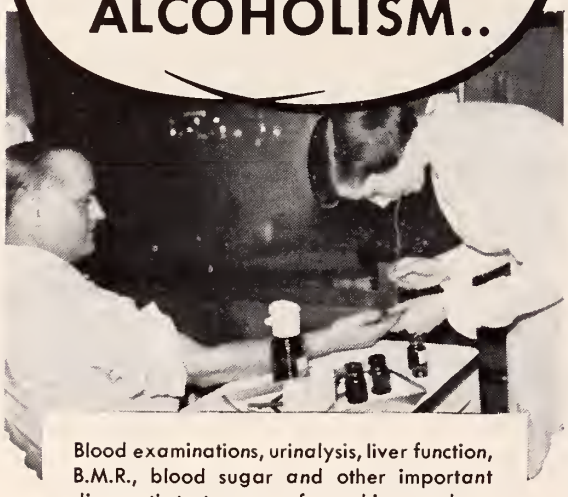

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Milwaukee Academy of Medicine

Dr. R. R. Linton of the department of surgery of Harvard Medical School was the guest speaker at the November 18 meeting of the Milwaukee Academy of Medicine. Doctor Linton conducted a special clinic on "Peripheral Vascular Problems" at the Veterans Administration Hospital, Wood, during the afternoon. At the regular evening meeting, the doctor's subject was "Surgical Treatment of Bleeding Esophageal Varices Secondary to Portal Hypertension."

Milwaukee Oto-Ophthalmic Society

The most recent monthly meeting of the Milwaukee Oto-Ophthalmic Society was held on November 25 at the Veterans Administration Hospital, Wood. Following dinner, a program was presented by the staff of the Hospital, featuring talks by Dr. J. H. Russell and *Dr. R. J. Schwarz*. The title of Doctor Russell's paper was "Affections of the Cranial Nerves," and Doctor Schwarz chose "Evaluation of Exophthalmos—Use of Orbitonometry" as his topic.

SOCIETY RECORDS

New Members

W. A. Joseph, 8601 West Greenfield Avenue, Milwaukee.

J. F. Behrend, 215 East Main Street, Sun Prairie.

Milton Davis, Jr., 1300 University Avenue, Madison.

D. R. Korst, 1300 University Avenue, Madison.

G. A. Landmann, 1018½ Superior Avenue, Tomah.

R. G. Konicek, 421 South Beaumont Road, Prairie du Chien.

H. A. Bjork, 625 Fifty-seventh Street, Kenosha.

P. J. Ambro, 625 Fifty-seventh Street, Kenosha.

E. C. Ferguson, 204 East Grand Avenue, Eau Claire.

A. A. Lorenz, 204 East Grand Avenue, Eau Claire.

K. E. Walter, 131 South Barstow Street, Eau Claire.

H. W. Mahaffey, 16 South Henry Street, Madison.

Changes in Address

James Nissenbaum, Philadelphia, Pennsylvania to 1823 Griswold Drive, Fort Wayne, Indiana.

J. M. Sinnett,* Waupun to Naval Air Station, Pensacola, Florida.

J. J. McLeod, Jr.,* Birchwood to Naval Administrative Command, USN Training Center, Building 109, Great Lakes, Illinois.

J. A. Booher, La Valle to 115 North Walnut Street, Reedsburg.

T. E. Kilkenny, Winneconne to 2122 Calhoun Street, New Orleans, Louisiana.

H. E. Schaefer,* Montgomery, Alabama to A02240773, S. A. M. Box 62, Randolph AFB, Texas.

F. J. Hofmeister, Wauwatosa to 2212 West State Street, Milwaukee.

G. A. Dedinsky,* Milwaukee to Box 73, Smock, Pennsylvania.

R. R. Brazy, Wood to 4600 North Woodburn Avenue, Milwaukee.

R. P. Still, Oak Park, Illinois to 435 Sherwood Drive, La Grange Park, Illinois.

R. C. Jackson, Superior to 1442 Damon Court, Rochester, Minnesota.

J. E. Sweeney, Marshfield to Fargo Clinic, 307 North Broadway, Fargo, North Dakota.

Alma Fogelberg, Madison to 106 West Underwood Street, Chevy Chase, Maryland.

W. H. Lohr,* San Francisco, California to 02096596, 6013th Army Service Unit, United States Army Hospital, Fort Lawton, Washington.

W. H. Zahl, Whitewater to 1230 West Grant Street, Milwaukee.

N. J. Kozokoff, Milwaukee to % M. Wohl, 130 Clem Road, San Antonio, Texas.

T. A. Gross, Madison to 4016 Estes Road, Nashville, Tennessee.

H. W. Wood, Jr., Oshkosh to 516 Mowbray Arch, Hague District, Norfolk, Virginia.

W. J. Kelly, Denver, Colorado to The Hilltop, Potosi.

D. P. Davis,* New York, New York to A02212398, 3840 South Fifth Street, Milwaukee.

* Military Service.

DEATHS

The name of **Dr. John Martin Kelley,** who died on August 28, will long be remembered in the territory surrounding Cato, where he served the community for almost 50 years. His Irish humor and gentle manners and disposition endeared him to all his patients and friends. When he made his rounds at the Maple Crest Sanatorium there was always a smiling greeting to all, and all felt better after he had visited them. He always had time to listen to all of their complaints. When the Sanatorium was opened in 1913, he was appointed consultant by the county board. Sanatorium care was new in those days and the feeling was that that was where you went to die. He was little known in those days, but before his retirement in 1951 he had been recognized nationally as an authority on T.B. and had appeared on many national programs.

When the call came for medical men in World War I, although he had a wife and four children and was beyond the draft age, he went into service and was a good soldier loved by all the men of the company. He was a member of the Gosz–Novak American Legion Post at Reedsville and served as one of its officers.

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Gallbladder Surgery, Ten Hours, starting April 20
Surgery of Colon & Rectum, One Week, starting March 2
General Surgery, One Week, starting February 9
General Surgery, Two Weeks, starting April 20
Fractures and Traumatic Surgery, Two Weeks, starting March 2
GYNECOLOGY—Intensive Course, Two Weeks, starting February 16
Vaginal Approach to Pelvic Surgery, One Week, starting March 2
OBSTETRICS—Intensive Course, Two Weeks, starting March 2
PEDIATRICS—Intensive Course, Two Weeks, starting April 6
MEDICINE—Intensive General Course, Two Weeks, starting May 4
Electrocardiography & Heart Disease, Two Weeks, starting March 16
Allergy, One Month and Six Months, by appointment
UROLOGY—Intensive Course, Two Weeks, starting April 13
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Last year when he resigned as medical superintendent of the Maple Crest Sanatorium, he was given a testimonial dinner which was attended by many nationally known men, and telegrams and letters were read from many former patients.

He served as president of the Manitowoc County Medical Society and also as president of the staff of the Holy Family Hospital. Long before the days of the county nurse he visited the rural schools of his community to examine the pupils—that was the first public health work done in the county.

As a young man he spent his summers on the Great Lakes as an officer on the steamship Manchester of which his father Tim Kelley was the captain. He was well versed in nautical history and always enjoyed reading a good nautical story.

Born in the city of Manitowoc on May 10, 1876, he was a graduate of the old Second Ward high school and then completed his medical work at Marquette Medical College, now Marquette University School of Medicine. After graduating in 1905 Doctor Kelley located for a time at Green Bay, and when Doctor O'Connell died in 1907 at Cato, Doctor Kelley took over his practice, where he was active until his retirement last year.

On June 15, 1910, he was married to Miss Sadie Brennen, who with three sons, Charles, Francis, and John and a daughter, Marion, survive him.—Prepared for the Journal by E. C. Cary, M. D., Reedsville.

Dr. Francis F. Bowman, 80, Madison health officer for 18 years, died on September 27 at a local hospital, following a brief illness.

Born in Madison on August 27, 1872, the doctor was a member of the class of 1894 of the University of Wisconsin, and then was graduated from Rush Medical College in 1897. He interned at Johnston Emergency Hospital in Milwaukee, and also at St. Joseph's Hospital in Chicago.

A veteran of the last of the Indian fighting, the Spanish–American War, and World I, he had practiced in Madison since 1903. He was appointed Madison health officer in 1928 and served at that post until his retirement in 1947. He had also served as an epidemiologist for eight years for the State Board of Health, following his return to Madison after World War I.

Doctor Bowman is survived by his wife, a son, and three grandchildren.

Dr. Peter J. Merten, a Milwaukee physician and surgeon for 43 years, died on October 14 at a local hospital. He was 73 years old.

Born on August 17, 1879, the doctor received his undergraduate education at Valparaiso (Ind.) University and was awarded his degree in medicine by the old Chicago College of Medicine and Surgery (now the Stritch School of Medicine of Loyola University.) In addition, he was a graduate in pharmacy. Upon his graduation he began practice in Milwaukee, where he remained except for a period of service with the army during World War I.

Doctor Merten was a member of the Medical Society of Milwaukee County, the State Medical Society, and the American Medical Association.

He is survived by his wife.

Dr. Otto F. Sporleder, 85, former Reedsburg physician, died on October 14 at a hospital in Baraboo, following an illness of about one year. He was born in Germany on January 22, 1867.

A graduate of Marquette University in 1907, he started practicing in Blackhawk and Loganville, moving to Reedsburg in 1914. He remained there until 1925. He also had an office in Mount Horeb for several years. Returning to Reedsburg the doctor practiced there until 1945, when he moved to Baraboo to make his home with his daughter.

Doctor Sporleder was a member of the Sauk County Medical Society, the State Medical Society, and the American Medical Association.

Surviving are his daughter and four sons.

Dr. Carl M. Akwa, physician at the Veterans Administration Hospital, Wood, died on October 15. He was 31 years old.

Born on September 19, 1921 in Milwaukee, the doctor was graduated from the University of Wisconsin Medical School in 1944. He interned at Mount Sinai Hospital and then served in the army for two years. Later, he served a year's residency in dermatology at the VA Hospital, Wood. Early in 1951 he was placed in charge of the rehabilitation ward of that hospital.

Doctor Akwa was a member of the Medical Society of Milwaukee County, the State Medical Society, and the American Medical Association.

Survivors included his wife, two sons, and two daughters.

Dr. Frederick F. Fowle, 84, former senior physician at the Milwaukee County Hospital for Mental Diseases, died at his home on October 19, after a brief illness. When he retired in 1940, Doctor Fowle had been affiliated with the hospital for 40 years.

The doctor attended the University of Nebraska for two years and was graduated from the University of Wisconsin in 1893. He received his M. D. degree at Rush Medical College, Chicago in 1900. He served his internship at Milwaukee County General Hospital, prior to joining the staff of the hospital for mental diseases.

He is survived by a daughter.

Dr. Arthur R. F. Grob, a general practitioner in Milwaukee for 64 years, died on October 22 at a local hospital after a short illness. He was 85 years old.

The doctor was born near Newton in Manitowoc County on November 14, 1866. He studied theology for several years before his interest changed to medicine. He enrolled in Hahnemann Medical College, from which institution he received his M. D. degree in 1888.

Doctor Grob had served on the staff of Hanover Hospital (now St. Luke's Hospital) and later on the

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MAR. 26 (Thurs.): Neenah ☐

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board of trustees of Johnston Emergency Hospital. He was a member of the American Institute of Homeopathy, the Wisconsin State Homeopathic Society, the Medical Society of Milwaukee County, the State Medical Society, and the American Medical Association.

Surviving are his wife, a son and a daughter.

Dr. Edward D. Stanton, Reedsburg physician, died on October 26 at his home, following an extended illness. He was 52 years old.

A native of Wisconsin, the doctor was born on April 29, 1900. He attended the University of Wisconsin Medical School, receiving his degree in 1928. His internship was served at Wisconsin General Hospital, Madison, and upon its completion he opened his office in Reedsburg, where he had practiced for 23 years. He was a member of the staff of the Reedsburg Municipal Hospital.

Doctor Stanton is survived by his wife.

Dr. W. R. Berg, 57, Gillett physician, died suddenly on October 28 at his home. He was born on February 27, 1895.

A native of St. Paul, Minnesota, the doctor received his medical degree from Marquette University School of Medicine and served his internship at the Bellin Memorial Hospital in Green Bay. He established his practice in Gillett and had served the community for 27 years.

Doctor Berg was active in civic affairs and frequently served on committees for community projects. A past president of the Oconto County Medical Society, he was also a member of the State Medical Society, and the American Medical Association.

Surviving are his wife, a son, and two daughters.

Dr. Adam L. Curtin, 65, Milwaukee physician and surgeon, died on November 3 at a local hospital. He had practiced in Milwaukee for 40 years.

Born in the town of Holland near Kaukauna on August 14, 1887, Doctor Curtin attended Marquette University School of Medicine for his M.D. degree. He graduated in 1912 and began an internship at Milwaukee County General Hospital. He served as house physician at Johnston Emergency Hospital, the Milwaukee County Emergency Hospital, and at Sacred Heart Sanitarium. A World War I veteran, he was a surgeon in the army, serving 24 months in France.

The doctor was a member of the Medical Society of Milwaukee County, the State Medical Society, and the American Medical Association.

He is survived by four brothers and three sisters.

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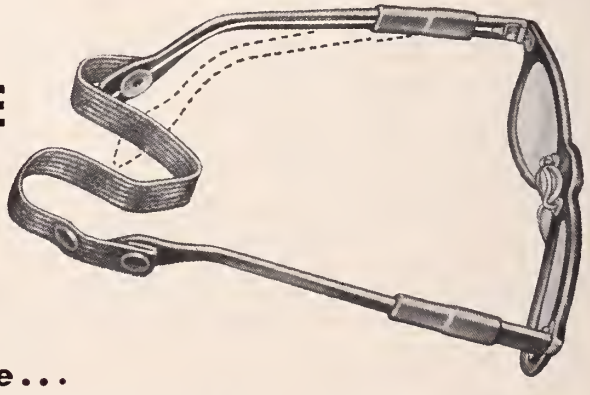

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RICAN MEDICAL ASSOCIATION news notes DECEMBER, 1952

AMA news written especially for use in state medical journals

More Bookings Seen for "Your Doctor" Film in '53

More and more Americans will have an opportunity to see the RKO–Pathe film, "Your Doctor," during 1953. An estimated 12 million persons viewed the 15-minute movie-short in more than 2,000 commercial theaters across the nation in 1952.

After January 1, 16 mm. prints of the film will be available for showings to schools, service clubs, civic groups, industrial plants, and special professional meetings. Produced by Louis de Rochemont in cooperation with the AMA, this film portrays the work of 35-year-old Dr. George Bond in his valley clinic in backwoods North Carolina.

The American Medical Association also has made arrangements to obtain prints for state and county society film libraries. Societies interested in purchasing a print at cost may write to the AMA Public Relations Department. Details on distribution methods will be made available later.

Doctor Bauer Writes Health Column

"Health for Today," an authoritative health column by Dr. W. W. Bauer, director of the AMA's Bureau of Health Education, will be syndicated six days a week from coast-to-coast through King Features Syndicate. The first article will appear January 5, 1953. In his column, Doctor Bauer will discuss mainly health subjects rather than disease. He has received authorization from the Board of Trustees.

Top Speakers Billed on Rural Health Program

Here's a brief glance at the "theater marquee" for the Rural Health Conference February 27–28 at the Roanoke Hotel, Roanoke, Virginia.

Principal "stars" include: Friday morning—Dr. F. S. Crockett, chairman of the AMA's Council on Rural Health, reviewing the last seven years in "Looking Back to Look Ahead." Friday afternoon—Dr. Carl S. Mundy, vice chairman of the Council, explaining various phases of financing rural medical care . . . Frank Peck, managing director, Farm Foundation, Chicago, "The Missing Item in the Family Budget" . . . Eugene Butler, editor, Progressive Farmer, Dallas, "Problems of Medical Care in the South."

Saturday morning, a series of success and accomplishment stories—Miss Lilyan Zindell, administrator of Perry County Memorial Hospital, Perryville, Missouri, will tell how a community planned and constructed a community hospital . . . Dr. Edmund Yantes, Wilmington, Ohio, will give a follow-up on the Clinton County Survey on over-all health problems in that area . . . Dr. B. N. Salzman, Mountain Home, Arkansas, will present a new general practitioner's viewpoint on facing problems in a rural community . . . Dr. Felix Underwood, director, Mississippi State Department of Health, will discuss medical scholarships.

Winding up the conference at Saturday's luncheon, Dr. Louis H. Bauer, AMA president, will tell "What Medicine Is Doing"—pointing out the Association's many services to its physician-members and the general public.

Here's New Film Catalog

A revised list of medical and health films has been prepared by the AMA's Committee on Medical Motion Pictures. Brief descriptions, running time, and rules and regulations are included in the catalog for 78 medical films which are available from the Committee. Copies of the list may be obtained from the Committee.

Plans Nearly Complete for Biggest AMA Meeting on Record

Hardly is the debris swept away from one AMA meeting when it's time to plan another . . . especially, when the next annual meeting of the Association is expected to top all previous records—including the total attendance of 15,667 physicians made at the centennial session of 1947 at Atlantic City.

As early as last spring, AMA headquarters staff men settled preliminary arrangements with contractors, truckers, decorators, and convention hall officials for the June meeting to be held in New York City.

During the first part of January, more than 5,280 square feet of exhibit space will be sold to approximately 350 commercial firms. Space has been allotted on the first three floors for the Technical Exposition and on the fourth floor for the Scientific Exhibit.

More than 12,000 hotel rooms in New York have been pledged for the convention. Physicians planning to attend the meeting may make their reservations as soon as the hotel advertisement appears in the *Journal of the AMA*.

SAMA Memberships Open to Physicians

"Keep up with the young men who are keeping up with you" is the theme of a fall campaign now under way by the Student American Medical Association to encourage physicians to join the organization as honorary members. This new membership category was created at the request of doctors who wish to keep in touch with the student side of medical education, reports David Buchanan, national president.

Honorary membership, with yearly dues of five dollars, entitles the physician to a subscription to the monthly 72-page Journal of the SAMA as well as participation in the annual convention and other activities of the association. Physicians and friends of the medical student interested in becoming honorary members should contact Mr. David Buchanan, Student American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois.

PHYSICIANS' EXCHANGE

Advertisements for this column must be received by the 25th of the month preceding month of issue. A charge is made of $2.00 for the first appearance of copy occupying 1 inch or less of space and $1.00 for each succeeding insertion of the same copy. Kindly accompany copy with remittance to cover number of insertions desired. Advertisements from members of the State Medical Society will be accepted without charge. Such copy will be taken out after its second publication unless otherwise requested. Where numbers follow advertisements replies should be addressed in care of The Wisconsin Medical Journal.

FOR SALE: One hundred milliampere x-ray, generator with tube stand, and tube for radiographic work. Very low price. Write to Mrs. M. P. Andrews, 835 N. 15th St., Manitowoc, Wis.

FOR SALE: Country practice with no competition. Only buy modern residence, with office and waiting room in residence—separate office entrance. Office in residence saves you office rent, phone, and secretary expense. Beautiful surroundings. Address replies to No. 440 in care of the Journal.

WANTED: A general practitioner to join Capital Clinic and Capitol Hospital group. Full or part time practice. Write 1971 West Capital Drive, Milwaukee, Wis. Phone, Uptown 1–9100.

WANTED: Midwest group of 20 physicians have opening for an assistant in general surgery including traumatic, industrial, and minor injuries; liberal salary depending upon experience or previous training. Address replies to box 454 in care of the Journal.

FOR SALE: Instruments and equipment of retiring eye, ear, nose, and throat physician who has been established in Wisconsin since 1916. Excellent opportunity for young man in city of 50,000. Address replies to box 449 in care of the Journal.

WANTED: Physician as an associate to general practitioner in North Shore area of Milwaukee. Eventual full partnership possibilities. Modern, well equipped, air conditioned offices. Must be well trained. Excellent opportunity. Address replies to box 430 in care of the Journal.

FOR SALE: Three hospital beds with mattresses in very good condition, $55 each. Also a very large assortment of surgical instruments that we will have to get together on in order to set a price. For further information write or call E. A. Jenkins, River Falls Clinic, River Falls, Wis.

PHYSICIAN WANTED, preferably out of internship, as associate in general practice which includes a liberal amount of surgery. Chance for partnership affiliation. Address replies to box 456 in care of the Journal.

GENERAL PRACTITIONER WANTED: A lucrative practice in a large rural area in northern Wisconsin available for a military exempt M. D. No competition, present physician specializing. Complete set of equipment available at token of real value if desired. Address replies to box 457 in care of the Journal.

PEDIATRICIAN would like to locate in Wisconsin with a group or as an associate. Interested in a city with a population between 8,000 and 40,000. Address replies to box 458 in care of the Journal.

THORACIC AND GENERAL SURGEON, qualified and certified, age 39, desires location, association or clinic. Straight thoracic surgery preferred. Presently Chief, Surgical Services and Thoracic Surgeon, Veterans Administration Hospital. Address replies to box 459 in care of the Journal.

AVAILABLE FOR YOUNG PHYSICIAN: Office space and equipment for general practitioner. Excellent location in business-residential section of Madison. Will arrange lease and ultimate purchase of equipment, if so desired. Write box 460 in care of the Journal to arrange for interview and inspection of office.

FOR SALE: All steel mahogany color examining table, instrument cabinet, stool, and waste receptacle. All pieces new except for slight damage to upholstery of examining table which can be repaired. Also brand new Castle sterilizer. Will sell all cheap to move fast. Address replies to box 461 in care of the Journal.

FOR SALE: Complete eye, ear, nose, and throat equipment, including all surgical, diagnostic, and refracting instruments. Make an offer for quick sale. Address replies to Mrs. D. G. Hugo, 508 Washington Blvd., Oshkosh, Wis.

PHYSICIAN WANTED to associate with three man, well established clinic, in a city of 4,000. Class A hospital connections. General practice and surgery. Address replies to box 462 in care of the Journal.

WANTED: Full or part time
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Write Box 144, South Milwaukee, Wis.
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FOR SALE: General and surgical practice in a village of 600 with excellent surrounding community, a small modern 16 bed hospital, and excellent home, situated on an acre of land. This business nets better than $15,000 per year. Address replies to box 138, Birnamwood, Wis.

EXPERIENCED PHYSICIAN WANTED, by a clinic in west-central Wisconsin, to replace a general practitioner who is going into service. Excellent salary. Address replies to box 463 in care of the Journal.

PHYSICIAN WANTED as an associate for a well established practice including surgery in a college and industrial city of about 6,000 in the Fox River Valley. Fully equipped and newly remodeled ground floor office of 12 rooms. Staff appointment open in 50 bed hospital. Salary, percentage, or private enterprise basis. Present M.D. owner unable to carry on practice alone due to health. Address replies to box 464 in care of the Journal.

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FOR SALE: Active general practice and equipment in modern office building in Manitowoc. Owner is Priority II and has been drafted. Outright sale, rent, or partnership considered. Address replies to box 466 in care of the Journal.

GENERAL SURGEON, four years training, large general hospital, age 33, desires association with general surgeon, group, or clinic. Call Milwaukee Spring 4–9314 or write box 467 in care of the Journal.

WANTED, oto-laryngologist for Metropolitan E.E.N.T. group. Must be certified or eligible for American Boards. Must be completely qualified in all branches. Extremely good financial and working arrangements leading to early partnership. Address replies to box 468 in care of the Journal.

FOR SALE: Resectoscope, never used. A.C.M.I. 28 French, complete with box, cords, lights, 2 sheaths, resecting unit, and extra cutting tips, etc. Address replies to box 469 in care of the Journal.

PHYSICIANS, with or without public health training, and pediatricians needed in maternal and child health program at salaries from $6,908 to $9,887. Five day week, pension, civil service appointment. Address replies to Dr. E. R. Krumbiegel, City Hall, Milwaukee, Wis.

PHYSICIANS WANTED: Obstetrician and gynecologist, preferably a young man, Board certified, the young man or woman to be associated in the department of pediatrics. Also a young man with one year surgical residency to be personal assistant to A. S. Jackson, M. D. Address replies to A. S. Jackson, M. D., 16 South Henry Street, Madison, Wisconsin.

FOR SALE: Mobile 30 milliampere x-ray unit in excellent condition. Direct writer electrocardiograph. Used Jones Basal Metabolism Unit. New microscope, demonstrator model, with stage, $179. Used microscope, $85. Slightly used film filing cabinet. Short wave in operating condition, $25. Address replies to C. C. Remington, 1204 W. Walnut St., Milwaukee 5, Wis. Call Locust 2–8118.

PHYSICIAN wanted to give pre-bath medical examination, heart and blood pressure only. Only 4 hours daily. Ideal for semi-retired or physically handicapped person. Room and meals. Prefer single person. Write or see N. B. Zepp, Manager, Moor Bath Hotel, Waukesha.

WANTED: Obstetrician, certified or Board qualified, for young progressive Wisconsin group. Excellent chances for development. Address replies to box 453 in care of the Journal.

FOR SALE: One 30 MA–90 KV Westinghouse X-Ray mobile unit, bucky table and other complete accessories. Office equipment including scale, exam table, surgical instruments and cabinet, short wave diathermy machine and B. D. Manometer. Write to Mrs. Viola Berg, Gillett, Wisconsin.

CORRESPONDENCE

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Dear Sir:

John Joanis has been out of town most of this month and has asked me to pass along to you our comments on your September issue of The Medical Forum.

We are, of course, very pleased to read the comments on Mr. Beach. All seem agreed that he was an asset to both his profession and our companies. It is, therefore, good to see him receive well deserved recognition in your paper. We appreciate very much the fact that you acknowledged the important role he played in establishing the Wisconsin Plan.

The Forum appears to be that type of paper to which the medical profession should be exposed. We think that the doctor as an individual has a tendency to become very uninterested and inactive in the political scene. The articles on Truman's Health Commission and the International Labor Organization meeting should help to create an interest. Certainly the doctor has an obligation to at least be informed on these and like subjects. Articles such as these will show him why he must become interested.

Yours very truly,
ROBERT F. FROEHLKE,
Legal Department

NATIONAL SOCIETY FOR MEDICAL RESEARCH
208 North Wells Street, Chicago 6, Illinois

Dear Sir:

I wish to thank you on behalf of our Board of Directors for your contribution of $50.00 in helping the Society continue its program for the coming year.

Please convey to the members of the Wisconsin State Medical Society our sincere appreciation of their continued interest and financial support.

Sincerely yours,
A. C. IVY, M.D., Ph.D.
SECRETARY–TREASURER

Office of the Surgeon
HEADQUARTERS FIFTH ARMY
1660 East Hyde Park Boulevard
Chicago 15, Illinois

Dear Sir:

We have your letter of 4 August as well as the January 1952 issue of the Wisconsin Medical Journal containing the article which outlines Army policy with respect to civilian medical attendance. Although we are required occasionally to return vouchers for further information, it appears that cases prepared by physicians and hospitals of the Wisconsin area are, generally speaking, being received in good form. Moreover, we feel that your explanation of these rules while it is, of necessity, quite general in scope, has stated the case very well.

By that orientation, you have rendered a definite service not only to the claimants, but as well to those of us of this headquarters who are equally interested in settlement of these accounts as promptly as possible.

Your cooperative approach to this problem is indeed greatly appreciated.

Very sincerely yours,
JOHN E. MERRIKEN
Lt Col, MSC, Asst Chief, Supply & Fiscal Division

MIDELFART CLINIC
Eau Claire, Wis.

Dear Sir:

I know it will be of interest to you to learn of the excellent meeting on industrial health which was held here in Eau Claire on Wednesday, April 2; and to learn of the tremendous interest that was shown in this meeting. It was attended by at least 125 persons including many doctors from this area, a large number of industrial and public health nurses and many factory managers and personnel managers in the industrial field.

The program consisted of three papers by well known physicians all of which were presented in such a way that they were enjoyed and appreciated by not only the medical profession but also by the laymen present. A tour of the United States Rubber Company Tire Plant and an excellent dinner at the Rubber Company completed the program.

Many thanks to your office for the help in organizing this meeting. This type of thing should be an annual affair.

Sincerely yours,
D. M. WILLISON, M.D.

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